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NOTES

ERISA PREEMPTION OF “ANY WILLING PROVIDER” LAWS—AN ESSENTIAL STEP TOWARD NATIONAL HEALTH CARE REFORM

I. INTRODUCTION

In his 1992 Presidential campaign, Bill Clinton focused national attention on health care reform in an attempt to win the approval of American voters.¹ The campaign and related media blitz on the health care reform debate made it common knowledge that thirty-five million Americans have no health insurance,² that health care costs represent fourteen percent of the gross domestic product of the United States³ and that the future of health care delivery lies in something known as “managed care.”⁴

1. See Ann Reilly Dowd, *His First 100 Days: The Outlook for Business*, FORTUNE, Nov. 30, 1992, at 41; *Rallying Around Reform*, NAT'L J., Sept. 5, 1992, at 2023; Lynn Wagner, *Small Business Lobby Opposes Clinton's Health Reform Plan*, MODERN HEALTHCARE, Oct. 5, 1992, at 6.

2. This number fluctuates, depending on the source, but is generally thought to be in the range of 35 million. Jeremy D. Rosner, *A Progressive Plan for Affordable Universal Health Care*, in MANDATE FOR CHANGE 107 (Will Marshall & Martin Schram eds., 1993) (citing U.S. HOUSE OF REPRESENTATIVES, COMMITTEE ON WAYS AND MEANS, 101ST CONG., 2D SESS., OVERVIEW OF ENTITLEMENT PROGRAMS: BACKGROUND MATERIALS AND DATA ON PROGRAMS WITHIN THE JURISDICTION OF THE COMMITTEE ON WAYS AND MEANS 323 (1990) and U.S. BUREAU OF THE CENSUS, No. 180, MONEY INCOME OF HOUSEHOLDS, FAMILIES, AND PERSONS IN THE UNITED STATES: 1991, at 60 (1992)); see also Gregory Cerio, *Why Are the 37 Million Uninsured?*, NEWSWEEK, Jan. 10, 1994, at 8; *Health Care Policy in the United States*, NAT'L J., Nov. 27, 1993, at 2856 (putting the number of uninsured at 33 million).

3. The proportion of the national output spent on health care in the United States doubled from 1977 to 1992, rising from 7% to 14%. Rosner, *supra* note 2, at 107 (citing U.S. DEPT. OF COMMERCE, U.S. INDUSTRIAL OUTLOOK 1992, at 43-53 (1992)). This number translates into a spending figure of \$950 billion in 1993. *HMO Movement Drives Changes in Healthcare; Health Maintenance Organizations*, CHEMICAL MARKETING REP., Dec. 6, 1993, at 26.

4. Valentine Cardinale, *Comes the Revolution; Health-Care Reform Column*, DRUG TOPICS, Dec. 13, 1993, at 10 (arguing that the importance of managed care organizations will continue to grow regardless of whether the Clinton health plan is adopted).

People often confuse the term “managed care” with “managed competition.” The two are different, yet closely related, features of the most prominent health care reform proposals. “Managed competition” occurs when health care providers compete to provide services through a market driven by purchasers of health care insurance. The theory is that an improved health care market will emerge from competition based on quality and cost. In contrast, “managed care organizations” (MCOs) administer the health care received by patients. Rosner, *supra* note 2, at 111 n.10. See *infra* note 8 for a discussion

Eleven months after his election, President Clinton presented the "Health Security Act" to Congress. Clinton's health care reform proposals failed to generate popular support on Capitol Hill, however, and fizzled into legislative oblivion by the end of the 103rd congressional term.⁵ Despite this initial setback, health care reform initiatives remain a pressing concern for the Administration, the Congress and the American people.

As new health care reform proposals emerge, one issue that must be addressed is the interrelation between national health care reform and the Employee Retirement Insurance Act of 1974 (ERISA).⁶ In particular, Congress will have to address the extent to which ERISA preempts existing state laws that regulate the structure of employer-based health care insurance.⁷

of the two predominant types of MCOs. Because MCOs typically charge a fixed rate for their services, they usually implement cost control and utilization review mechanisms in order to maximize profits. PRACTICING LAW INSTITUTE, HEALTH CARE LAW 1993, at 549-50 (1993). Thus, MCOs represent a logical means by which health care providers can join together in an effort to succeed in a managed competition environment.

5. H.R. 3600, 103d Cong., 1st Sess. (1993); S. 1757, 103d Cong., 1st Sess. (1993).

President Clinton introduced the Health Security Act on November 20, 1993. He obtained 100 cosponsors of the bill in the House of Representatives and 30 in the Senate. Five other health reform bills were also submitted to Congress under separate sponsorship. Steven Findlay, *Jockeying for Position*, BUS. & HEALTH, Jan. 1994, at 18. However, President Clinton and other Democratic leaders announced near the end of the 103rd congressional term that they could not overcome Republican opposition to their health care bills. See Dana Priest, *Democrats Pull the Plug on Health Care Reform*, WASH. POST, Sept. 27, 1994, at A1. Neither the House nor the Senate ever voted on Clinton's health care bill. Dana Priest & Michael Weisskopf, *Health Care Reform: The Collapse of a Quest*, WASH. POST, Oct. 11, 1994, at A6.

6. 29 U.S.C. § 1001 et seq. (1988). A few months before officially revealing their plan for health care reform, Clinton Administration officials indicated that the plan would be "aimed at substantially changing [ERISA]." However, these changes were said to be aimed at giving states more ability to regulate the structure of health insurance plans funded by employers. *President Clinton's Plan Will Include Substantial ERISA Changes, Officials Say*, 20 PENSION & BENEFITS REP. (BNA) No. 33, at 1625 (Aug. 2, 1993).

7. ERISA § 514(a) contains the Act's broad preemption clause which provides that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a) (1988).

ERISA plays a critical role in health policy because over 70% of health care insurance in the United States is purchased through employer-based health insurance plans. Jill Hodges & Darlene DePass, *Insurance Concerns Affect Job Choices, Many Workers Say*, STAR TRIBUNE, June 16, 1993, at 1A. The U.S. Bureau of Labor Statistics indicates that, in 1993, 69% of employees at companies with 100 or fewer employees were covered by employer-based health insurance, and 83% of employees at larger companies had employer-based coverage. *Id.* In 1991, of the 212 million Americans covered by health insurance, 67% received this coverage through their employer. ERNST & YOUNG, HEALTH CARE DATA REFERENCE CARD DECEMBER 1993 (1993).

Experts consistently cite managed care alternatives⁸ as the central paradigm around which a uniform national health care reform policy must

8. See, e.g., Jeffrey B. Schwartz, *The Preferred Provider Organization as an Alternative Delivery System*, 6 J. LEGAL MED. 149 (1985). Managed care organizations vary in form according to the degree to which members' care is "managed" by the organization. The two most common forms of managed care organization are health maintenance organizations (HMOs) and preferred provider organizations (PPOs). Within each of these general categories, however, significant variances may exist. Robert A. Blum & William F. Brossman, *Basic Legal Issues for Employers in Managed Care*, C799 A.L.I.-A.B.A. 509, 514-15 (1993); see also Cathy L. Burgess, Comment, *Preferred Provider Organizations: Balancing Quality Assurance and Utilization Review*, 4 J. CONTEMP. HEALTH L. & POL'Y 275, 277 (1988) (classifying PPOs by "sponsorship categories"); S. BRIAN BARGER ET AL., THE PPO HANDBOOK 17-19 (1985) (providing a "Summary Compendium of PPO Variations").

HMOs generally exercise a great deal of control over the price and quality of health care received by their members. Blum & Brossman, *supra*, at 515. An HMO is ordinarily composed of an exclusive group of health care professionals known as a "closed group." VERGIL N. SLEE & DEBORA A. SLEE, HEALTH CARE TERMS 195 (2d ed. 1991). The closed group usually either owns its own hospital or contracts with several different hospitals for use of a set number of beds. *Id.* HMO participants purchase their health care insurance by making periodic payments of a "fixed capitation amount" to the HMO. Schwartz, *supra*, at 150. The payment of the fixed fee guarantees an HMO participant access to all necessary medical and hospital care so long as such care is covered by the insurance contract and provided exclusively by members of the closed panel.

HMOs are sometimes referred to as "risk contractors." SLEE & SLEE, *supra*, at 195. The HMO accepts a fixed fee from its participants and, in turn, assumes the risk that some participants will require care in excess of that covered by the fixed fee. Moreover, the HMO's health care providers typically receive fixed annual salaries for providing all necessary care to any participating member. Blum & Brossman, *supra*, at 515. Consequently, part of the risk that an HMO participant will require extra care is shifted to the providers of care. This HMO feature is often cited as the most significant difference between HMOs and PPOs. SLEE & SLEE, *supra*, at 341; see also Schwartz, *supra*, at 150.

In comparison to HMOs, PPOs exercise less control over the actual care received by their participants. The typical PPO is "an organization of physicians and hospitals that contracts with employers or insurers to provide comprehensive health care services to subscribers on a fee-for-service basis." Schwartz, *supra*, at 150 (citing D.H. COWAN, PREFERRED PROVIDER ORGANIZATIONS: PLANNING, STRUCTURE AND OPERATION 9 (1984)). The physicians and hospitals agree to accept discounted payments, on a fee-for-service basis. *Id.* These providers, in turn, hope to receive a larger patient volume to offset the discount. SUSAN HOSEK ET AL., THE RAND CORPORATION, THE STUDY OF PREFERRED PROVIDER ORGANIZATIONS—EXECUTIVE SUMMARY 1 (1990).

Unlike HMO physicians, PPO physicians do not risk providing services in excess of fees received. Instead, the party paying for the health care services retains the risk that the demand for care will increase. SLEE & SLEE, *supra*, at 341. In order to maintain a successful coverage plan, therefore, a PPO must contract with a panel of preferred providers large enough to meet its subscribers' needs yet small enough to minimize the cost of the risk assumed. See HOSEK ET AL., *supra*, at 1. In addition, the panel must contain only as many providers as will allow the insurer or employer to meet utilization review requirements. See Burgess, *supra*, at 282-84 (indicating a need for independent "utilization review firms"). Utilization review requirements ensure both an efficient use of resources and a sustained level of quality care from preferred providers. *Id.* at 276.

Finally, unlike an HMO, a PPO offers its members an option to "swing out" of the preferred panel of providers. Blum & Brossman, *supra*, at 515. PPO subscribers who wish to receive health care goods or services from providers outside the preferred panel usually must pay part or all of any additional costs above the discounted fee offered by preferred providers. See Schwartz, *supra*, at 150.

be based,⁹ but state law restrictions threaten this ideal.¹⁰ Statutory provisions known as “any willing provider”¹¹ laws are a primary example

9. See, e.g., Rosner, *supra* note 2, at 112-13 (discussing a plan for universal, national health care insurance coverage based on “health insurance purchasing cooperatives,” or “HIPC’s,” which offer a range of managed care plans to consumers). Rosner presumes that state laws restricting such managed care arrangements would have to be preempted in order for his proposals to succeed. *Id.* at 113. He suggests that ERISA would provide the mechanism for this preemption. *Id.* at 113 n.15.

10. See *ERISA Preemption Brings Uniformity to Benefit Plan Regulation*, ERIC Says, 20 Pens. Rep. (BNA) No. 9, at 534 (Mar. 1, 1993). The President of the ERISA Industry Committee argued that “[i]f Congress . . . allows states to regulate health plans, attention will be deflected from the need for national [health care] reform. . . .” *Id.*; see also Joanne Wojcik, *Curbs on Managed Care Hike Health Costs: Study*, BUS. INS., Aug. 19, 1993, at 3 (citing WYATT CO., COST ANALYSIS OF STATE LEGISLATIVE MANDATES ON SIX MANAGED HEALTH CARE PRACTICES (1991)).

Attempts to establish universal health care insurance coverage through a national health care policy in the United States have come and gone since the beginning of the twentieth century. PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 243 (1982).

11. See *infra* notes 17-20 and accompanying text. A report conducted by the Wyatt Company in 1991 described these laws as follows:

The “any willing provider” mandate requires that managed care networks accept any willing provider that meets the network’s established selection criteria. Such mandates are usually intended to insure that all licensed health care practitioners in a state are allowed equal access to patients who join managed health care plans.

WYATT CO., COST ANALYSIS OF STATE LEGISLATIVE MANDATES ON SIX MANAGED HEALTH CARE PRACTICES 3 (1991) [hereinafter WYATT REPORT]. In addition, the report delineates the positions most commonly taken by proponents and opponents of these laws. Proponents concede that PPOs need to select preferred providers based on set criteria, but “they want the [provider selection] criteria to be . . . evenly applied to all licensed providers state-wide.” *Id.* Opponents of any willing provider laws put forth two arguments. First, they contend that in order to achieve the most economically sound panel of providers, PPOs need to select providers based on “a mixture of criteria [including] needs analysis, credentialing committee review, discount negotiations and market demands” Second, the opponents maintain that making set terms available to all providers statewide prevents PPOs from excluding any more than a few providers from the preferred panel. *Id.*

Four separate categories of laws are currently designated under the broad heading of “any willing provider” laws:

- [1] “freedom of choice” laws that require insurers to reimburse a non-network provider as long as the provider agrees to accept the insurer’s level of reimbursement for the service; . . .
- [2] “mandatory admittance” laws that require insurers to include in a network any provider willing to abide by the terms and conditions of the network, including price; . . .
- [3] “due process” laws that require insurers to follow certain procedures in creating and maintaining a network, such as publishing the criterion for participation in the network and providing for an appeal process in the event of termination of a provider from participation in a network; . . .
- [4] “essential community provider” laws that require insurance networks to contract with essential community providers serving medically needy, poor populations, e.g. community health centers and AIDS providers.

Andrew L. Jiranek & Susan D. Baker, *Any Willing Provider Laws: Regulating the Health Care Provider’s Contractual Relationship with the Insurance Company*, HEALTH LAW. (ABA Forum on Health Law), Winter 1994-1995, at 3.

Although many of the economic and legal issues discussed in this Note relate to all four categories of any willing provider laws, the Note directly addresses only those laws listed in the second category above.

of current state health care regulation that thwarts the growth of managed care alternatives.¹² Any willing provider laws are usually incorporated into a state's insurance code, and they specifically affect a managed care alternative known as a preferred provider organization (PPO).¹³ One of the most viable managed care alternatives, PPOs offer low cost, high quality health care to insured members willing to forgo some freedom in choosing their health care provider.¹⁴ To provide these benefits efficiently, PPOs must be able to limit the number of health care providers within their program.¹⁵

Most state codes purport to allow insurance companies to offer health care coverage through PPOs.¹⁶ However, over twenty states currently have any willing provider laws¹⁷ or provisions that have the same practical

12. Any willing provider laws are only one of several forms of state regulation in the health insurance industry that prevent the growth of large managed care plans. Warren Greenburg, *Fewer Insurers Can Improve Competition*, BUS. & HEALTH, Dec. 1992, at 56. Mr. Greenburg argues that there are three other ways in which managed care growth is artificially constrained by state regulation: most-favored nation clause prohibitions, McCarran-Ferguson Act exemptions for small insurers, and Blue Cross and Blue Shield Association territorial licensing restrictions. *Id.* at 55-56.

Inconsistent state legislation also hinders the establishment of multistate PPOs. Burgess, *supra* note 8, at 279-80. Previous public support for federal preferred provider legislation may have been stymied by increased state preferred provider legislation. *Id.* at 280. However, national employer groups and unions argue that increased state legislation will "balkanize the health care system into 50 separate health fiefdoms, weaken the reform effort overall, and generally lead to chaos." Steven Findlay, *States vs the Feds: Who Gets Control?*, BUS. & HEALTH, Aug. 1993, at 56.

13. See *supra* notes 8, 11.

14. See BARGER ET AL., *supra* note 8, at 27. PPOs offer significant benefits to consumers and providers alike. *Id.* at 27-29. The viability of PPOs is evidenced by their rapid growth since the late 1970s and early 1980s—when health costs first began increasing at rates beyond the means of most employers. *Id.* at 6-7. The number of operational PPOs in the United States grew from a mere 10 to over 100 from 1981 to 1984. *Id.* at 4. PPOs then grew nearly ten-fold again, to over 1000, between 1984 and 1992. Memorandum from the American Association of Preferred Provider Organizations 2 (Jan. 31, 1994) (on file with author) (citing data from SMG Marketing Group Inc., Chicago, June 1993).

However, arrangements between large groups of organized consumers and medical service providers are not a recent phenomenon in the United States. As early as 1890, certain workers guilds and fraternal societies reaped the benefits of contractual agreements with doctors. In fact, during the first quarter of the twentieth century, doctors often used discounted fees to entice people to use their services. See STARR, *supra* note 10, at 206-07.

15. See *infra* note 20 and accompanying text.

16. Burgess, *supra* note 8, at 277 n.22 (citing ROLPH, STATE LAWS AND REGULATIONS GOVERNING PREFERRED PROVIDER ORGANIZATIONS 32 (1986)).

17. See *Any Willing Provider Laws Spreading*, MANAGED CARE LAW OUTLOOK (SPECIAL REPORT), July 1994, at S4, S4-S5 (charting 1994 data from the Blue Cross and Blue Shield Association and the Group Health Association regarding all 50 states' current and pending any willing provider legislation).

effect.¹⁸ The typical state any willing provider provision mandates that "[n]o hospital, physician or type of [health care] provider . . . willing to meet the terms and conditions offered to it or him shall be excluded [from a preferred provider arrangement]."¹⁹ This provision effectively prohibits the delivery of health care through selectively chosen providers.²⁰ Yet, the freedom to select only a *limited number* of providers is essential to the success of preferred provider organizations. Therefore, determining whether any willing provider laws should be preempted by ERISA is an important step in achieving a coherent national health care policy.

On June 4, 1993, the Fourth Circuit offered a new opinion on the ERISA preemption debate.²¹ In *Stuart Circle Hospital Corp. v. Aetna Health*

18. Paul J. Kenkel, "Any Willing Provider" Laws Pose Threat to Reform - Trade Groups, MODERN HEALTHCARE, Aug. 9, 1993, at 100. So-called "open pharmacy" laws, currently enacted in 17 states, have the same practical effect as "any willing provider" laws on the ability of managed care organizations to use preferred providers for pharmaceutical goods. *Id.*

19. VA. CODE ANN. § 38.2-3407 (Michie 1994). Virginia's any willing provider law, encompassed within the statutory sections addressing accident and sickness insurance, provides:

A. One or more insurers may offer or administer a health benefit program under which the insurer or insurers may offer preferred provider policies or contracts that limit the numbers and types of providers of health care services eligible for payment as preferred providers.

B. Any such insurer shall establish terms and conditions that shall be met by a hospital, physician or type of provider listed in § 38.2-3408 in order to qualify for payment as a preferred provider under the policies or contracts. These terms and conditions shall not discriminate unreasonably against or among such health care providers. No hospital, physician or type of provider listed in § 38.2-3408 willing to meet the terms and conditions offered to it or him shall be excluded. Neither differences in prices among hospitals or other institutional providers produced by a process of individual negotiations with providers or based on market conditions, or price differences among providers in different geographical areas, shall be deemed unreasonable discrimination. The Commission shall have no jurisdiction to adjudicate controversies growing out of this subsection.

Id.

20. See *supra* notes 8, 11. If a PPO must make itself available to every provider within a state, the essential incentives for providers to offer discounted rates—increased market share and patient volumes—disappear. A 1983 study performed by the California Hospital Association concluded that 95% of hospitals contract with PPOs to increase their market share, and 88% contract with PPOs to increase their occupancy rates. BARGER ET AL., *supra* note 8, at 28. A provider invited to join a PPO cannot offer discounted rates to the PPO's subscribers without some guarantee that the provider's preferential status will translate into a larger volume of patients.

Moreover, a PPO forced to have an "open" panel of providers, rather than a select, or "closed," panel, would quickly run into problems maintaining cost and efficiency controls over the resultant large number of providers. *Id.* at 20 (noting that, as a practical matter, "open panel PPOs are nearly impossible"). Some of the most common cost and efficiency control mechanisms employed by PPOs are preadmission certifications, length of stay reviews, appropriateness of claims analysis, retrospective claims reviews, mandatory second opinions for elective surgery, and overall utilization review of practice patterns. *Id.* at 22.

21. *Stuart Circle Hosp. Corp. v. Aetna Health Management*, 995 F.2d 500, 501 (4th Cir.), *cert. denied*, 114 S. Ct. 579 (1993). See notes 21-25, 95-129 and accompanying text for discussion of the

Management,²² the Fourth Circuit held that ERISA does not preempt Virginia's any willing provider provision, which is encompassed within the state's PPO statute.²³ Aetna Health Management asserted that Virginia's any willing provider law was preempted by ERISA under the Act's was broad language mandating preemption of any state laws that "relate to any

Stuart Circle decision.

Few courts have addressed ERISA preemption issues involving any willing provider laws. The *Stuart Circle* court cited a 1985 holding by the Supreme Court of Missouri as precedent for its decision. *Id.* at 505. However, the statutes the Supreme Court of Missouri addressed did not operate as any willing provider laws. In *Blue Cross Hospital Service, Inc. v. Frappier*, 698 S.W.2d 326 (Mo. 1985) (en banc), the Missouri Supreme Court analyzed two separate statutes. The first operated as a classic "mandated provider" law, see *infra* notes 72-76 and accompanying text, requiring insurance plans to cover the services of chiropractors and psychologists to the extent that such providers were licensed to provide services covered by the plan. *Frappier*, 698 S.W.2d at 326-27. The second statute operated as a "mandated benefit" law: it prohibited preferred provider arrangements with pharmacies. *Id.* at 327; see also *infra* notes 65-71 and accompanying text (discussing mandated benefit laws). The second Missouri statute prohibited insurers to allow insureds to receive the same reimbursement for drugs purchased at any pharmacy regardless of whether the pharmacy participated in a contractual arrangement with the insurer. *Frappier*, 698 S.W.2d at 327. Relying on the *Metropolitan Life* ruling handed down by the Supreme Court only a few months earlier, see *infra* notes 57-61 and accompanying text, the Supreme Court of Missouri correctly found that both Missouri statutes were preempted by ERISA. *Frappier*, 698 S.W. 2d at 327 (citing *Metropolitan Life Ins. Co. v. Massachusetts Travelers Ins. Co.*, 471 U.S. 724 (1985)).

Although the *Frappier* court did not face the unique issue raised by any willing provider laws, just six months prior to *Stuart Circle*, the Supreme Court of Virginia decided a case virtually identical to *Stuart Circle*. See *Blue Cross and Blue Shield v. St. Mary's Hosp.*, 426 S.E.2d 117 (Va. 1993). In *St. Mary's Hospital*, the plaintiff hospital claimed that Blue Cross discriminated against the hospital when it negotiated its preferred provider contracts. *Id.* at 119. The only difference between *St. Mary's Hospital* and *Stuart Circle* is the specific section of the Virginia Code used by the plaintiffs to gain access to the PPO. Compare *id.* at 118 with *Stuart Circle*, 995 F.2d at 501. Both statutes function as any willing provider laws—allowing PPO arrangements, but also mandating that "[n]o hospital . . . willing to meet the terms and conditions offered . . . shall be excluded." VA. CODE ANN. § 38.2-4209(B)-(C), 38.2-3407(A)-(B) (Michie 1994). In *St. Mary's Hospital*, the court held that Virginia's any willing provider law was not preempted by ERISA. *St. Mary's Hospital*, 426 S.E.2d at 122.

In *Stuart Circle*, the Fourth Circuit cited the *St. Mary's Hospital* decision as support for its holding. *Stuart Circle*, 995 F.2d at 505. In doing so, the Fourth Circuit employed the same faulty rationale as the Supreme Court of Virginia. Both courts treated any willing provider laws as equivalent to mandated benefit laws in order to bring the laws within the *Metropolitan Life* holding. *Id.* at 503; *St. Mary's Hospital*, 426 S.E.2d at 121. This Note argues that courts must differentiate between any willing provider laws and mandated benefit laws. In so doing, courts should find that ERISA preempts the any willing provider laws. See *infra* Part III.

22. *Stuart Circle Hosp. Corp. v. Aetna Health Management*, 995 F.2d 500 (4th Cir.), *cert. denied*, 114 S. Ct. 579 (1993).

23. *Stuart Circle*, 995 F.2d at 505. The managed care industry views this holding as a major setback to the continued success of managed care alternatives such as PPOs. Alicia W. Roberts, *High Court: 'Any Willing Provider' Laws Safe from ERISA Preemption*, MANAGED CARE OUTLOOK, Dec. 3, 1993, at 1, 1-2.

employee benefit plan.”²⁴ The Fourth Circuit disagreed, and held that Virginia’s entire PPO statute, including its any willing provider provision, qualifies as a law that “regulates insurance” under ERISA section 514(b)(2)(A) and is thus “saved” from preemption.²⁵

This Note challenges the *Stuart Circle* court’s rationale and suggests that the current basis upon which courts determine the fate of any willing provider laws is both ambiguous and flawed.²⁶ Part II outlines the general ERISA preemption of laws that “regulate insurance.” Part III draws important distinctions between any willing provider laws and other laws that courts have classified as laws that regulate insurance.²⁷ Part IV demonstrates that conflicting results will likely emerge as courts address ERISA preemption of any willing provider laws. Finally, Parts V and VI propose means by which courts and Congress can eliminate any future confusion as to the status of any willing provider laws under ERISA.²⁸

24. *Stuart Circle*, 995 F.2d at 501-02.

25. *Id.* at 503.

26. *Stuart Circle* represents the first federal appellate decision to specifically address an any willing provider law. In *Stuart Circle*, the Fourth Circuit claimed that Tenth Circuit precedent supported its holding. *Stuart Circle*, 995 F.2d at 505 (citing *Blue Cross and Blue Shield of Kansas City v. Bell*, 798 F.2d 1331, 1334-36 (10th Cir. 1986)). However, the Tenth Circuit, in *Bell*, held only that mandated provider laws, not any willing provider laws, are preempted by ERISA—a determination that the Supreme Court previously made in *Metropolitan Life, Bell*, 798 F.2d at 1334 (citing *Metropolitan Life*, 471 U.S. at 741).

27. In *Stuart Circle*, the Fourth Circuit failed to make this distinction. The Fourth Circuit first stated that Virginia’s any willing provider law prohibited an “unreasonable restriction of providers.” 995 F.2d at 503. The court then went on to find that “mandatory-provider regulations are conceptually similar to the mandatory-benefit law that *Metropolitan Life* held was a law regulating insurance . . .” *Id.* In so finding, the Fourth Circuit ignored the clear differences between any willing provider laws and the “matrix of state laws” which “regulate the substantive content of health insurance policies.” See *Metropolitan Life*, 471 U.S. at 729; see also *infra* Part III.

28. The abolition of state laws that prevent the development of managed care alternatives represents an essential first step toward creation of a viable, uniform national health care policy. The Health Maintenance Organization Act of 1973, 42 U.S.C. §§ 300e-1 to 17 (1988), contains a provision designed to prevent states from impeding the efficient operation of qualified health maintenance organizations. In § 300e-10, entitled “Restrictive State laws and practices,” the Act provides:

(a) In the case of any entity - (1) which cannot do business as a health maintenance organization in a State . . . because that State by law, regulation or otherwise - . . . (C) requires that all physicians or a percentage of physicians in the locale participate or be permitted to participate in the provision of services for the entity . . . such requirements shall not apply to that entity so as to prevent it from operating as a health maintenance organization in accordance with . . . this title.

42 U.S.C. § 300e-10 (1988). The Senate Committee on Labor and Public Welfare determined that the preemption of restrictive state laws in this manner was a valid exercise of congressional authority under both the Supremacy Clause and the Commerce Clause. S. REP. NO. 129, 93d Cong., 1st Sess. 27 (1973).

In 1973, PPOs had not yet emerged as one of the viable options in the national health care reform debate. However, it was clear even then that “some form of health maintenance organization designed

II. ERISA PREEMPTION VERSUS STATES' AUTHORITY TO REGULATE INSURANCE

Government regulation of employee benefit plans was a matter of national concern even before President Ford signed ERISA into law in 1974.²⁹ As early as 1958, President Eisenhower saw the Welfare and Pension Plan Disclosure Act as setting a "precedent" for federal regulation of employee benefit plans.³⁰ In addition, prior to ERISA, Congress had also enacted federal standards regarding the taxation of pension and profit sharing plans.³¹ However, until 1974, states retained primary control over the creation and administration of employee benefit plans.³²

A. *Legislative History and Language of ERISA Section 514*

The passage of ERISA was driven in large part by the desire for a uniform national system to regulate employee benefit plans.³³ To implement ERISA, Congress employed its broad Commerce Clause powers to preempt state laws that might impede its goal.³⁴ ERISA section 514(a), the preemption clause, provides that "the provisions of this subchapter . . . shall supersede any and all State laws insofar as they . . . relate to any employee

for more efficient and economic services are [sic] strategic to any attempt to restructure the present practices of delivering health care, and that the Federal Government must play a lead role in assisting in the development of such organizations." *Id.* at 7. The Committee viewed the removal of restrictive state barriers as essential "in order that the full purposes and objectives of [the HMO Act] be accomplished and executed." *Id.* at 27.

29. JOHN H. LANGBEIN & BRUCE A. WOLK, PENSION AND EMPLOYEE BENEFIT LAW 69 (1990).

30. *Id.* at 59.

31. *Id.* at 363.

32. *Id.*

33. At the time ERISA was enacted, any willing provider laws were not part of the congressional debate over ERISA's preemptive power. Evidence suggests that, in 1974, health insurers did not foresee the magnitude of the effect that ERISA would have on their industry. Moreover, congressional committees responsible for drafting ERISA did not consult members of a health subcommittee about ERISA's final preemptive language or its potential effect on health care. Daniel C. Schaffer & Daniel M. Fox, *Semi-Preemption in ERISA: Legislative Process and Health Policy*, 7 AM. J. TAX POL'Y 47, 54 (1988).

34. In comments made just prior to the passage of ERISA, Representative Dent stated: With the preemption of the field [of employee benefit plans], we round out the protection afforded participants by eliminating the threat of conflicting and inconsistent State and local regulation. We followed to a large extent the same approach as . . . where the regulation of health maintenance organizations was foreclosed to State authority.

120 CONG. REC. 29,197 (1974).

benefit plan.”³⁵ This language represents the broadest possible preemption.³⁶ The preemption clause completely forecloses state regulation of employee benefits, even in areas that federal law does not regulate specifically.³⁷

ERISA’s preemption clause thus creates a regulatory gap in areas such as health care insurance benefits where federal statutes do not address some of the major regulatory issues.³⁸ Yet, legislative history, the plain language of the preemption clause, and the statements contained in ERISA’s original “Declaration of Policy” demonstrate that Congress intended ERISA’s broad

35. 29 U.S.C. § 1144(a) (1988). The full language of the preemption clause states:

Except as provided in subsection (b) of this section, the provisions of this Subchapter and Subchapter III shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b). This section shall take effect on January 1, 1975.

Id.

A “State law” is defined under ERISA § 514(c)(1) as including “all laws, decisions, rules, regulations, or other State action having the effect of law, of any State.” 29 U.S.C. § 1144(c)(1) (1988).

36. See Leon E. Irish & Harrison J. Cohen, *ERISA Preemption: Judicial Flexibility and Statutory Rigidity*, 19 U. MICH. J.L. REF. 109, 110-12 (1985). Criticizing the breadth of ERISA’s preemption clause, Irish and Cohen argue that, if applied literally, this provision forces courts to preempt “any state law that touches upon an employee pension or welfare plan.” *Id.* at 112. The authors further state:

The literal approach also makes it embarrassingly clear that Congress enacted ERISA while still oblivious to numerous problems related to benefit plans that states had already recognized. . . . [The] primary shortcoming of section 514 is that, although it establishes a good starting point for thinking about ERISA preemption, it falls short both as a practical rule and as a guide to principled decision making. Courts have thus had little choice but to create a federal common law of ERISA, including preemption, in spite of, and to some extent hindered by, the literal language of the statute.

Id.

37. Schaffer & Fox, *supra* note 33, at 48. Schaffer and Fox note that one participant involved in the original drafting of ERISA dubbed the preemption provision a “regulatory vacuum.” *Id.*

38. *Id.* at 55-56. Schaffer and Fox refer to ERISA’s preemption scheme as “semi-preemption” because it gives states the authority to regulate some, but not all, aspects of health insurance. If employer-based health insurance is purchased through an insurance company, then under ERISA’s semi-preemption, a state can exercise regulatory authority. If, on the other hand, the same health insurance is provided through an employer’s self-insured program, ERISA preempts any state involvement. *Id.* at 47.

The recent history of health care reform in the United States sheds some light on ERISA’s regulatory gap with regard to health care. From the 1930s until the late 1970s, the federal government made periodic attempts to develop a national health care system. Thus, when ERISA’s drafters made the final touches on the preemption clause, House and Senate sponsors concerned about the regulatory gap in health care believed that the health care gap might soon be filled by federal law. In the late 1970s, however, policymakers began to focus on cost controls, and their efforts to create a national health care insurance system faded. The election of Ronald Reagan signalled a new mindset that the states, rather than the federal government, are the most appropriate testing ground for health care reform. Schaffer & Fox, *supra* note 33, at 55; see STARR, *supra* note 10, at 380.

preemptive reach.³⁹ In fact, major union lobbying forces supported the amendment of ERISA's original, more narrow, preemption clause in order to achieve preemption of certain state health insurance laws, despite the lack of federal regulation in this area.⁴⁰

Congress did place some limit on the scope of ERISA preemption, however. Even before the preemption clause reached its final form, ERISA's "saving clause" was already in place.⁴¹ ERISA section 514(b)(2)(A) states that "nothing in this subchapter shall be construed to

39. While the original language of the preemption clause "simply prevented the states from legislating about the 'subject matters regulated by this Act,'" Schaffer & Fox, *supra* note 33, at 48 (quoting H.R. 2, 93d Cong., 2d sess. 3669(a) (1974) (as amended by Senate)), Congress added broader preemption language only days before the final legislation was passed. Lawmakers touted the broader language as the "crowning achievement of this legislation . . . [eliminating] . . . [the] threat of conflicting and inconsistent state and local regulation." *Id.* (quoting 120 CONG. REC. 29,197 (1974)).

ERISA § 2 contains the "Findings and Declaration of Policy" behind the enactment of ERISA. It provides in part:

(a) The Congress finds that the growth in size, scope and numbers of employee benefit plans in recent years has been rapid and substantial; that the operational scope and economic impact of such plans is increasingly interstate; that the continued well-being and security of millions of employees and their dependents are directly affected by these plans; that they are affected with a national public interest; . . . that they have become an important factor in commerce because of the interstate character of their activities, and of the activities of their participants, and the employers, employee organizations, and other entities by which they are established or maintained; . . . that owing to the lack of employee information and adequate safeguards concerning their operation, it is desirable in the interests of employees and their beneficiaries . . . that . . . safeguards be provided with respect to the establishment, operation, and administration of such plans

U.S.C. § 1001(a) (1988).

40. See Schaffer & Fox, *supra* note 33, at 53. Unions supported broad preemption of state health insurance laws even though some state laws mandated desirable benefits in insurance contracts. *Id.* Organized labor viewed the loss of such benefits as a necessary concession to prevent state interference with national contracts and collective bargaining. *Id.* Of course, in 1974 the union lobbyists had no idea that, just over a decade later, the Supreme Court would find state-mandated benefit laws to be outside ERISA's preemptive reach. See *Metropolitan Life*, 471 U.S. at 746. In *Metropolitan Life*, the Court recognized that the continued preemption of mandated benefit laws would "eliminate some of the disuniformities currently facing national plans that enter into local markets to purchase insurance." *Id.* at 747. Nonetheless, the Court found that the preemption of mandated benefit laws was "the inevitable result of the congressional decision to 'save' local insurance regulation." *Id.*

Union forces also supported ERISA's broad preemptive power in hopes of preserving access to prepaid, "closed panel" legal services through benefit plans. Robert S. McDonough, Note, *ERISA Preemption of State Mandated-Provider Laws*, 1985 DUKE L.J. 1194, 1201. The debate over such legal services presents an interesting analogy to the debate over PPO statutes taking place today. Interest groups such as the American Bar Association supported "open panel," prepaid legal service arrangements. These arrangements, as opposed to "closed panel" arrangements, allowed all lawyers to participate in providing legal services for a plan's members. In the end, "[t]he ERISA preemption clause was broadened largely because organized labor and consumer groups feared that states and bar associations would block the formation of 'closed panel' prepaid legal plans" *Id.*

41. McDonough, *supra* note 40, at 1201 n.42 (citation omitted).

exempt or relieve any person from any law of any State which regulates insurance."⁴² This clause reconciles ERISA's broad preemption provision with the McCarran-Ferguson Act of 1945.⁴³ The McCarran-Ferguson Act established that, notwithstanding the broad reach of Congress' power over interstate commerce, the authority to regulate insurance should remain primarily with the states.⁴⁴

The question presented by this statutory framework is whether any

42. 29 U.S.C. § 1144(b)(2)(A) (1988). The full language of the saving clause provides: "(2)(A) Except as provided in subparagraph (B), nothing in this Subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." *Id.*

Regarding the operation of ERISA's saving and preemption clauses, the Supreme Court remarked that these provisions "perhaps are not a model of legislative drafting, for while the general pre-emption clause broadly preempts state law, the saving clause appears broadly to preserve the States' lawmaking power over much of the same regulation." *Metropolitan Life*, 471 U.S. at 739-40. The Court commented further that "[w]hile Congress occasionally decides to return to the States what it has previously taken away, it does not normally do both at the same time." *Id.* at 740.

ERISA's preemption provisions are further complicated by the so-called "deemer" clause, which provides:

(B) Neither an employee benefit plan . . . nor any trust established under such plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

29 U.S.C. § 1144 (b)(2)(B) (1988).

43. McCarran-Ferguson Act, ch. 20, 59 Stat. 33 (1945) (current version at 15 U.S.C. §§ 1011-1015 (1988)).

44. Congress initiated the McCarran-Ferguson Act soon after the Supreme Court's landmark holding in *United States v. South-Eastern Underwriters Association*, 322 U.S. 533 (1944). In *South-Eastern Underwriters*, the Court held for the first time that the insurance industry was, in fact, subject to federal regulation under the Commerce Clause. *Id.* In response to this decision, the McCarran-Ferguson Act provided that:

(a) The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.
(b) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: *Provided*, That [the federal antitrust laws] shall be applicable to the business of insurance to the extent that such business is not regulated by State law.

15 U.S.C. § 1012(a)-(b) (1988).

The McCarran-Ferguson Act essentially reversed the effect of the Supremacy Clause with regard to the insurance industry. According to the Supremacy Clause, U.S. CONST. art. VI, cl.2, federal laws preempt conflicting state laws. However, through the McCarran-Ferguson Act, Congress expressly provided that state insurance laws can only be preempted by federal laws that specifically relate to the business of insurance. State laws that regulate insurance, therefore, enjoy a power of supremacy over federal regulation that is not specifically aimed at the insurance industry.

For a more complete discussion of the McCarran-Ferguson Act and the history of the insurance exemption, see Charles D. Weller, *The McCarran-Ferguson Act's Antitrust Exemption for Insurance: History and Policy*, 1978 DUKE L.J. 587.

willing provider laws are preempted by ERISA or whether they fall under the saving clause. Determining the answer entails a two-step process. One must first ask whether the laws in question "relate to any employee benefit plan."⁴⁵ If so, the laws are within the scope of ERISA preemption. Assuming this first question is answered in the affirmative, one must then ask whether the laws "regulate insurance."⁴⁶ If any willing provider laws regulate insurance, they fall within ERISA's saving clause and, accordingly, are not preempted by ERISA. If any willing provider laws do not regulate insurance, then they are subject to ERISA preemption.

B. Supreme Court Interpretation of ERISA's Preemption Clause

The Supreme Court interprets the "relate to" language of section 514(a) broadly.⁴⁷ To determine whether conduct qualifies as "the business of insurance" and escapes ERISA preemption under the saving clause, the Court uses a specific three-part test.⁴⁸ The test asks three questions about

45. See 29 U.S.C. § 1144(a) (1988). An "employee benefit plan" is defined as "an employee welfare benefit plan or an employee pension benefit plan or a plan which is both an employee welfare benefit plan and an employee pension benefit plan." 29 U.S.C. § 1002(3) (1988). In turn, an "employee welfare benefit plan" is defined as "any plan . . . established or maintained by an employer or by an employee organization . . . to the extent that such plan . . . [is] for the purpose of providing . . . through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits in the event of sickness, accident, disability, death or unemployment . . ." 29 U.S.C. § 1002(1) (1988).

46. See 29 U.S.C. § 1144 (b)(2)(A) (1988).

47. See, e.g., *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 98 (1983). In *Shaw*, the Court held that New York's "Human Rights Laws" related to employee benefit plans under ERISA § 514(a). The Court looked to the legislative history of the preemption clause, and noted:

The bill that became ERISA originally contained a limited pre-emption clause, applicable only to state laws relating to the specific subjects covered by ERISA. The Conference Committee rejected these provisions in favor of the present language, and indicated that the section's pre-emptive scope was as broad as its language.

Id. (footnotes omitted) (citing H.R. CONF. REP. NO. 1280, 93d Cong., 2d Sess. 383 (1974); S. CONF. REP. NO. 1090, 93d Cong., 2d Sess. 383 (1974), reprinted in 1974 U.S.C.C.A.N. 4639).

The *Shaw* Court further noted that the Subcommittee on Labor Standards of the House Committee on Education and Labor issued a report specifically addressing whether ERISA's preemption provisions required clarification. The Committee found that "the Federal interest and the need for national uniformity are so great that enforcement of state regulation should be precluded," and recommended a narrower saving clause. *Id.* at 99 n.20; see also *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47 (1987) (citing *Shaw* and holding that common law actions for breach of contract relate to employee benefit plans within the meaning of ERISA § 514(a)).

48. See *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 128 (1982) (citing *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979)).

In 1979, the Supreme Court interpreted the phrase "business of insurance" as used in § 2(b) of the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-15 (1945). *Royal Drug*, 440 U.S. at 210. While section 2(b) specifically left the regulation of the "business of insurance" to the individual states, Congress failed to define the "business of insurance." *Id.* at 211. Thus, in *Royal Drug* the Court embarked on a

the practice that a state law regulates: (1) whether the practice effects the transfer or spreading of a policyholder's risk;⁴⁹ (2) whether the practice is an integral part of the relationship between the insured and the insurer; and (3) whether the practice is confined to entities within the insurance industry.⁵⁰

Justice Stewart originally applied this three-part "business of insurance" test in *Group Life & Health Insurance Co. v. Royal Drug*.⁵¹ In *Royal Drug*, eighteen pharmacy owners in San Antonio, Texas brought a federal antitrust action against the Group Life and Health Insurance Co. (Blue Shield).⁵² These owners complained that Blue Shield unfairly excluded them from agreements between Blue Shield and other pharmacies in the area.⁵³ Under the agreements, Blue Shield's insured members would have to pay only a two dollar deductible if they bought their prescription drugs from one of the "participating" pharmacies; Blue Shield paid the remainder of the cost.⁵⁴ If a member bought prescription drugs from a "nonparticipating" pharmacy, however, the member would have to pay the two dollar deductible plus twenty-five percent of the remainder of the cost.⁵⁵ Thus, Blue Shield encouraged its members to use only the pharmacies with which Blue Shield contracted. Applying the three-part test, the Supreme Court held that the agreements between Blue Shield and its participating pharmacies did not constitute the "business of insurance."⁵⁶

landmark analysis and attempted to outline the three fundamental elements for identifying the "business of insurance" and the laws that regulate it. *Id.* at 211-24.

Three years after *Royal Drug*, in *Pireno*, the Court summarized its criteria for determining whether a practice constitutes the "business of insurance": "first, whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry." *Pireno*, 458 U.S. at 129.

49. Courts consistently cite R.E. KEETON, INSURANCE LAW § 1.2(b) (1971), in support of the statement that the spreading and underwriting of risk constitute "the primary elements of an insurance contract." See, e.g., *Royal Drug*, 440 U.S. at 211; *Blue Cross and Blue Shield of Kansas City v. Bell*, 798 F.2d 1331, 1335 (10th Cir. 1986) ("Risk . . . is the essence of the bargain evidenced by an insurance contract.").

50. *Pireno*, 458 U.S. at 129.

51. 440 U.S. 205 (1979).

52. *Id.* at 207.

53. *Id.* at 209. Blue Shield offered the agreements to every pharmacy in Texas. The plaintiff pharmacy owners, however, could not make a profit under the agreements and thus were unable to participate. *Id.*

54. *Id.*

55. *Id.*

56. *Id.* at 232-33. Because *Royal Drug* involved the application of federal antitrust law, the determination that the preferred provider arrangement was *not* the "business of insurance" meant that

During the fifteen years following *Royal Drug*, Justice Stewart's opinion gained recognition as establishing the standard for determining which practices qualify as the "business of insurance" under the McCarran-Ferguson Act.⁵⁷ And, just a few years after *Royal Drug*, the Court adopted

federal antitrust law could preempt Texas antitrust law. *Id.* On the other hand, had the Texas law regulated antitrust activity within the "business of insurance," it would not have been preempted. *See supra* notes 41-44 and accompanying text.

The arrangement at issue in *Royal Drug* is essentially identical to the structure of the typical PPO. A typical PPO contracts with certain health care providers to grant discounted prices to insured members. Similarly, in *Royal Drug*, Blue Shield contracted with certain pharmacies to provide discounts on prescription drugs to its members. In addition, just as Blue Shield's members shouldered a monetary penalty for choosing a nonparticipating pharmacy, a typical PPO insurance policy obligates members who choose a nonparticipating provider to pay all or part of the additional cost charged by that provider. These factual similarities strongly suggest that PPOs, like the contractual agreement in *Royal Drug*, do not qualify as the business of insurance. Accordingly, an any willing provider law that attempts to regulate the number of contractual arrangements made by PPOs cannot qualify as a law that "regulates insurance."

This conclusion is supported by the *Royal Drug* Court's reliance on the D.C. Circuit's reasoning in *Jordan v. Group Health Association*, 107 F.2d 239 (D.C. Cir. 1939). The health care arrangement at issue in *Jordan* is directly analogous to preferred provider arrangements in use today. Group Health Association was a nonprofit corporation organized to provide medical services and supplies for its members. The organization accepted fixed annual fees from members and contracted with providers who agreed to accept discounted fees. *Jordan*, 107 F.2d at 241-44. The *Jordan* court held that Group Health's arrangements did not constitute insurance because insurance companies are concerned primarily with risk. Group Health, on the other hand, "[was] concerned principally with getting services rendered to its members and doing so at lower prices made possible by quantity purchasing and economies in operation." *Id.* at 245-47. The *Royal Drug* Court found *Jordan* applicable to the arrangements in *Royal Drug* and "illustrative of the contemporary view of health-care plans." *Royal Drug*, 440 U.S. at 227.

57. *See* *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982) (discussing the "three elements" identified in *Royal Drug* for determining whether a practice constitutes the "business of insurance"). The *Royal Drug* test has become the touchstone for deciding the "insurance" issue in the ERISA preemption context primarily because of the lack of legislative history discussing ERISA's saving clause or its relationship to the Act's general preemption clause. *See* *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 743 (1985); *see also* *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 51 (1987) (applying the three *Royal Drug* criteria to determine whether state common law of "bad faith" regulates insurance under ERISA); *Blue Cross and Blue Shield of Kansas City v. Bell*, 798 F.2d 1331, 1335 (10th Cir. 1986) (applying the three criteria to determine whether state mandated provider laws are exempt from preemption under ERISA).

The Supreme Court recently limited the *Royal Drug* holding as it relates to the McCarran-Ferguson Act itself. *United States Dep't of Treasury v. Fabe*, 113 S. Ct. 2202, 2209 (1993). In *Fabe*, the court addressed whether an Ohio statute was "enacted 'for the purpose of regulating the business of insurance.'" *Id.* at 2208 (quoting 15 U.S.C. § 1012(b)). The Ohio statute, known as a "priority statute," regulates the liquidation of insolvent insurance companies. *Id.* at 2204 (citing OHIO REV. CODE ANN. § 3903.42 (Anderson 1989)). The Court held that the statute regulates insurance "to the extent that it regulates policyholders . . . [However,] [t]o the extent that it is designed to further the interests of other creditors . . . it is not a law enacted for the purpose of regulating the business of insurance." *Id.* at 2212.

With respect to the McCarran-Ferguson Act itself, the *Fabe* Court clarified the rule established by

the same three-part test for determining whether a practice constitutes the "business of insurance" in the ERISA context.⁵⁸ In *Metropolitan Life Insurance Co. v. Massachusetts*,⁵⁹ the Supreme Court first extended the application of the *Royal Drug* criteria to its interpretation of ERISA's saving clause and the phrase "regulates insurance."⁶⁰ The Court reasoned that the "business of insurance" must be defined consistently for purposes of both ERISA and the McCarran-Ferguson Act.⁶¹ Thus, *Royal Drug's*

Royal Drug and *Pireno*. *Fabe*, 113 S. Ct. at 2209. According to *Fabe*, those cases "held only that 'ancillary activities' that do not affect performance of the insurance contract or enforcement of contractual obligations do not enjoy the antitrust exemption for laws regulating the business of insurance." *Id.* (quoting *Pireno*, 458 U.S. at 134 n.8). The *Fabe* court, moreover, drew a distinction between the first and second clauses of § 2(b) of the McCarran-Ferguson Act. *Id.* See *supra* note 44 for the text of § 2(b) of the McCarran-Ferguson Act. The Court explained that the first clause of § 2(b) defined the states' broad power to regulate "the business of insurance." *Id.* The meaning of this clause was the central issue in *Fabe*. *Id.* On the other hand, the Court viewed the second clause of § 2(b) as a more narrow exemption from federal antitrust laws. The meaning of this clause was the issue in both *Royal Drug* and *Pireno*. *Id.* For a complete discussion of the bifurcated scope of § 2(b) of the McCarran-Ferguson Act, see Davis J. Howard, *Uncle Sam Versus the Insurance Commissioners: A Multi-Level Approach to Defining the "Business of Insurance" Under the McCarran-Ferguson Act*, 25 WILLAMETTE L. REV. 1 (1989).

Nowhere in *Fabe* did the Court alter the application of the *Royal Drug* test to ERISA. Rather, *Fabe* merely established that, under the language of the McCarran-Ferguson Act, a state law that does not meet all three of the *Royal Drug* criteria may still constitute a law "enacted for the purpose of regulating insurance." *Fabe*, 113 S. Ct. at 2209-12. However, the Court also limited the extent to which this can occur—even under the Court's broad interpretation of the McCarran-Ferguson Act's first clause. That is, a state law must directly affect policyholders' interests in order to escape preemption. *Id.* at 2212. Conversely, a law is subject to preemption if it is "designed to further the interests of other[s] . . ." *Id.* The *Fabe* court explicitly "rejected the notion that . . . indirect effects [on insurance] are sufficient for a state law to avoid pre-emption under the McCarran-Ferguson Act." *Id.* (citing *Royal Drug*, 440 U.S. at 217).

58. See *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985).

59. *Id.*

60. Prior to *Metropolitan Life*, Congress had an opportunity to interpret the saving clause. In 1979, the First Circuit held that ERISA did not preempt a New Hampshire mandated benefit law. *Wadsworth v. Whaland*, 562 F.2d 70, 73 (1st Cir. 1977), *cert. denied*, 435 U.S. 980 (1978). A bill introduced into Congress in 1979 intended to overrule the *Wadsworth* decision by amending ERISA to preempt state mandated provider laws. See *Metropolitan Life*, 471 U.S. at 740 n.16 (citing S.209, 96th Cong., 1st Sess. (1979)). However, this bill was neither debated nor enacted. *Id.* (citing SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES, 96th Cong., LEGISLATIVE CALENDAR 108, 111 (final ed., Jan. 4, 1981)).

61. *Metropolitan Life*, 471 U.S. at 744 n.21. The Court explained in a footnote that:

[t]he ERISA saving clause, with its similarly worded protection of "any law of any State which regulates insurance," appears to have been designed to preserve the McCarran-Ferguson Act's reservation of the business of insurance to the States. The saving clause and the McCarran-Ferguson Act serve the same federal policy and utilize similar language to define what is left to the States.

Id.

three-part test for the business of insurance is now the controlling standard within the ERISA preemption context.⁶²

III. DISTINGUISHING ANY WILLING PROVIDER LAWS

Because any willing provider laws perform a unique regulatory function, they do not fall in the same category with other laws that "regulate insurance."⁶³ Judicial interpretations of ERISA section 514(b)(2)(A) have correctly given states primary authority to regulate the *types* of health care benefits and the *types* of providers that insurance companies must offer as part of any health insurance contract.⁶⁴ States exercise this authority through laws known as "mandated benefit" and "mandated provider" laws. However, these laws are distinguishable from any willing provider laws under the three-part test for laws which "regulate insurance."

In *Metropolitan Life*, the first Supreme Court case to apply the *Royal Drug* test in the ERISA context, the plaintiffs challenged Massachusetts' "mandated benefit" law. The law required that any general insurance policy, accident or sickness policy, or employee health policy include coverage for certain specified mental health risks.⁶⁵ Like many other mandated benefit laws,⁶⁶ the Massachusetts law afforded policyholders

62. Today, courts called on to decide whether a law "regulates insurance" under ERISA refer to "the *Metropolitan Life* test" as the precedent for employing the three-part test created in *Royal Drug*. See, e.g., *Tingle v. Pacific Mut. Ins. Co.*, 996 F.2d 105, 110 (5th Cir. 1993) (holding that a state law must meet all three of the *Royal Drug* criteria to avoid ERISA preemption). The Fifth Circuit noted that four other circuits have followed this "trend": *Brewer v. Lincoln Nat. Life Ins. Co.*, 921 F.2d 150, 153 (8th Cir. 1990), *cert. denied*, 111 S. Ct. 2872 (1991); *McMahan v. New England Mut. Life Ins. Co.*, 888 F.2d 426, 428-30 (6th Cir. 1989); *Kelley v. Sears, Roebuck and Co.*, 882 F.2d 453, 456 (10th Cir. 1989); and *Anschultz v. Connecticut Gen. Life Ins. Co.*, 850 F.2d 1467, 1468 (11th Cir. 1988). *Tingle*, 996 F.2d at 110 n.25.

This Note argues, in part, that future courts may find the three-part *Royal Drug* test inappropriate in light of ERISA's full preemption language. See *infra* Part IV.B.

63. Any willing provider laws are unique in that they regulate both the business of health care and the market for health care providers. Thus, this Note suggests that courts designate them as "health laws." See *infra* Part V.

64. See *Metropolitan Life*, 471 U.S. at 743-44. The Court stated that Congress intended to leave to the states the power to regulate "[t]he relationship between insurer and insured, the type of policy which could be issued, its reliability, its interpretation, and enforcement - these were the core of the 'business of insurance.'" *Id.* (quoting *SEC v. National Securities, Inc.*, 393 U.S. 453, 460 (1969)). At least one author has argued that *Metropolitan Life* should not apply to mandated provider laws. See McDonough, *supra* note 40, at 1205-06. However, the Tenth Circuit holds otherwise. See *Bell*, 798 F.2d at 1334.

65. *Metropolitan Life*, 471 U.S. at 729-30.

66. Mandated benefit laws are growing in popularity. In 1985, over 20 states had some form of mandated benefit law. *Id.* at 729 n.8. By 1992, over 35 different state legislatures had either passed or

certain benefits that the insurance companies would not have offered in the absence of a statutory requirement.⁶⁷ The *Metropolitan Life* Court applied the *Royal Drug* three-part test and determined that the Massachusetts mandated benefit law regulated the “business of insurance.”⁶⁸ First, the Court noted that mandated benefit laws serve as a means of spreading the risk of paying for a particular disease or disorder.⁶⁹ Second, the Court found that the laws regulate an integral part of the relationship between the insurer and the insured because they limit the type of policy that can be sold by an insurer.⁷⁰ Finally, the Court found that mandated benefit laws satisfied the third *Royal Drug* criterion because the laws’ requirements directly affect the relationship between the insurer and the insured.⁷¹

“Mandated provider” laws receive the same analysis as mandated benefit laws under the *Royal Drug* test. Mandated provider laws require an insurer to shoulder both the risk of the occurrence of certain ailments and the risk that the insured will choose to receive care from a particular type of physician. While mandated provider laws differ slightly from mandated benefit laws, the general effect of both laws is essentially the same: insurers are forced to offer benefits to their policyholders which the insurers would not otherwise offer.⁷² Specifically, mandated provider laws require insurers

were in the process of considering mandated benefit laws. See AMERICAN ASSOCIATION OF PREFERRED PROVIDER ORGANIZATIONS, SUMMARY OF STATE LEGISLATION IN HEALTH AND MANAGED CARE (1992).

67. *Metropolitan Life*, 471 U.S. at 734. The Attorney General of Massachusetts brought suit against Metropolitan Life Insurance Company and Travelers Insurance Company because the two companies issued insurance policies that did not offer the required mental health coverage. *Id.*

68. *Id.* at 743.

69. *Id.* The Court reasoned that the Massachusetts law “was intended to effectuate the legislative judgment that the risk of mental-health care should be shared.” *Id.*

70. *Id.*

71. *Id.* The Court explained that the Massachusetts mandated benefit law satisfied the third *Royal Drug* criterion because it “impose[d] requirements only on insurers, with the intent of affecting the relationship between the insurer and the policyholder.” *Id.*

When the *Pireno* Court originally gleaned the three criteria from *Royal Drug*, the third criterion asked “whether the *practice* is limited to entities within the insurance industry.” *Union Labor Life Ins. v. Pireno*, 458 U.S. 119, 129 (1982) (emphasis added). As in *Royal Drug*, the *Pireno* Court determined whether the defendants’ business practices constituted the “business of insurance.” See *Royal Drug*, 440 U.S. at 207; *Pireno*, 458 U.S. at 122. In ERISA preemption cases such as *Metropolitan Life*, however, the issue is whether a state statute “regulates insurance” as required by § 514(b)(2)(A). See *Metropolitan Life*, 471 U.S. at 739-47. Thus, the *Metropolitan Life* court transformed the third *Royal Drug* criterion to ask whether a state statute “impose[s] requirements only on insurers, with the intent of affecting the relationship between the insurer and the policyholder.” *Id.* at 743.

72. For a list of mandated provider laws in the United States, see McDonough, *supra* note 40, at 1194 n.8. McDonough argues that mandated provider laws are different from mandated benefit laws in that mandated provider laws do not add to “the scope of coverage.” *Id.* at 1202. However, courts

to pay for covered health care services so long as they are rendered by particular types of licensed providers.⁷³ In *Blue Cross and Blue Shield of Kansas City v. Bell*,⁷⁴ the Tenth Circuit held that mandated provider laws constitute the "business of insurance" for purposes of both the McCarran-Ferguson Act and ERISA's saving clause.⁷⁵ Therefore, the Tenth Circuit found that mandated provider laws satisfy the *Royal Drug* criteria because they specifically regulate the spreading of risk between the insurer and the insured.⁷⁶

have rejected this distinction. See *infra* note 73; see also *Blue Cross Hosp. Serv., Inc. v. Frappier*, 698 S.W.2d 326, 327 (Mo. 1985) (stating that there is "no viable distinction between the mandated benefit provisions involved in *Metropolitan Life* and our mandated provider statutes").

73. For example, a mandated provider law might require an insurer offering coverage for obstetric and neonatal services to pay for these health care services regardless of whether they are rendered by an obstetrician or a nurse midwife. This type of statute meets almost any definition of "insurance" because it "regulates the substantive terms of the insurance contract." See *Metropolitan Life*, 471 U.S. at 741.

Additionally, a mandated provider law like the one described above satisfies the three *Royal Drug* criteria. It regulates a spreading of risk because the insurer assumes the entire risk of pregnancy at the moment the contract is made between the insurer and the insured. See *Bell*, 798 F.2d at 1335 (stating that "the insureds right to choose the type of practitioner . . . must figure into . . . 'the spreading and underwriting of a policyholder's risk'" (citing *Royal Drug*, 440 U.S. at 211)). Further, the insurer assumes not only the risk of an insured becoming pregnant, but also the risk that the insured will choose alternate forms of treatment for that pregnancy. In this way, the mandated provider law broadens the scope of risk covered in the insurance contract. Unlike mandated provider laws, however, any willing provider laws do not effect the spreading of risk. Any willing provider laws do not regulate the choices that must be offered to the insured in the insurance contract, but the choices that must be offered to providers. See *infra* notes 86-91.

Mandated provider laws also regulate an integral part of the relationship between the insurer and the insured because they require the insurer to provide the insured with specific choices among types of providers. The Tenth Circuit explained that "[t]he freedom to choose a treating physician is inextricable from the nature of the coverage provided." *Bell*, 798 F.2d at 1335. By contrast, any willing provider laws do not regulate the insured-insurer relationship because they do not regulate the amount of choice that must be offered to the insured.

Finally, mandated provider laws "impose requirements only on insurers with the intent of affecting the relationship between the insurer and the policyholder." *Metropolitan Life*, 471 U.S. at 743. On the other hand, any willing provider laws regulate the relationship not between the insurer and the insured but rather between the insurer and the provider.

74. 798 F.2d 1331 (10th Cir. 1986).

75. *Id.* at 1336. The Kansas statute at issue in *Bell* required, among other things, that reimbursement be provided for covered services rendered by optometrists, dentists and podiatrists. See KAN. STAT. ANN. § 40-2100 (1993). The Tenth Circuit found that this statute met all three *Royal Drug* criteria. *Bell*, 798 F.2d at 1335.

76. *Id.* The Tenth Circuit explained that:

The policy determines the scope of coverage, that is, whether [the insurer] has assumed the risk of the entire loss. Implicit in the coverage of [an ailment] is the insured's choice of deliverer of the care. The choice of a provider does not add to the insured's coverage but is of the essence of that coverage bargained for as the transferred risk.

In contrast to mandated benefit and mandated provider laws, any willing provider laws do not satisfy *Royal Drug's* three criteria. First, because any willing provider laws do not mandate the terms of the contract between the insurer and the insured, they cannot effect a spreading of risk.⁷⁷ Any willing provider laws regulate preferred provider contracts which, by definition, do not involve risk spreading.⁷⁸ Preferred provider contracts, like the arrangements in *Royal Drug*, "are merely arrangements for the purchase of goods and services."⁷⁹ Under preferred provider arrangements, insurers contract with a limited number of providers in order to *reduce* the cost of the risk which the insurer has already assumed from the insured. However, preferred provider contracts do not further spread the insured's

Id.; see also *supra* notes 71-72 and accompanying text.

77. See *supra* notes 48-50 and accompanying text.

78. See *supra* note 8 and accompanying text. Any willing provider laws must be distinguished from other managed care alternatives that require providers to accept capitated salaries as payment for delivery of care to all policyholders. Under these typical arrangements, the providers assume some of the risk that a particular disease or disorder will occur within the member population and require care. There is no real dispute that health maintenance organizations (HMOs) function as "risk contractors," and, therefore, would be subject to any state insurance laws in the absence of specific federal preemption. See SLEE & SLEE, *supra* note 8, at 195; BARGER ET AL., *supra* note 8, at 42-43, 180. For this reason, Congress enacted federal HMO regulation in order to remove regulatory barriers to HMO development created by inconsistent state laws. See *supra* note 34 (discussing the legislative purpose behind the HMO Act of 1973). It may soon become necessary for Congress to enact equivalent PPO legislation.

However, unlike an HMO, the typical preferred provider organization does not operate as a risk spreading entity, and thus is not subject to state insurance regulation. BARGER ET AL., *supra* note 8, at 180. In light of this, federal regulation for PPOs equivalent to the HMO Act of 1973 seems unnecessary. Moreover, this may explain, in part, the relatively unnoticed appearance and consequent disappearance of the Preferred Provider Health Care Act of 1983, H.R. 2956, 98th Cong., 2d Sess. (1983). In May 1983, the PPO bill was introduced by Mr. Wyden in the House of Representatives to the Committee on Energy and Commerce. BARGER ET AL., *supra* note 8, at 1. Furthermore, the proposed PPO Act explicitly attempted to preempt state laws that prevented the development of PPOs. See H.R. 2956 § 2. In 1983, barely 100 PPOs existed in the United States. See *supra* note 14. The assumption that a federal PPO Act was unnecessary, along with the relatively sparse number of PPOs in 1983, may have contributed to the quiet death of the PPO Act in committee.

A convincing argument can be made for renewed consideration of federal PPO legislation. First, some have speculated that the PPO industry may begin using capitated reimbursement systems within the preferred provider model. BARGER ET AL., *supra* note 8, at 180. The use of a capitated system would make a PPO equivalent to the HMO model to the extent that there would be a spreading of risk to the preferred providers. Second, many states have initiated legislation intended to regulate PPOs. See *supra* note 15 and accompanying text. Finally, PPOs in the United States now number more than 1000 and provide coverage to more than 57 million people. See Memorandum from the American Association of Preferred Provider Organizations, *supra* note 14, at 2.

79. *Royal Drug*, 440 U.S. at 214.

risk to the provider.⁸⁰ Thus, any willing provider laws simply do not regulate the spreading of risk—the first essential element to qualify as the “business of insurance.”⁸¹

Similarly, preferred provider arrangements fail to satisfy the second element of the *Royal Drug* test. The second element asks whether the any willing provider law regulates an integral part of the relationship between the insured and the insurer. With regard to the analogous pharmacy agreements in *Royal Drug*, the Court relied on its earlier decision in *SEC v. National Securities, Inc.* and concluded that the agreements simply were “not ‘between the insurer and the insured.’”⁸² The Court reasoned that contractual arrangements between an insurer and providers who sell and distribute goods and services other than insurance do not affect the insurer-insured relationship sufficiently to constitute insurance.⁸³ Under this holding, particularly in light of the factual similarities between the pharmacy agreements in *Royal Drug* and PPOs, the preferred provider arrangements do not regulate an integral part of the relationship between the insured and the insurer.

However, even without this precedent, independent factors prevent any willing provider laws from satisfying the second or third *Royal Drug* criteria. Any willing provider laws are part of a state’s larger attempt to

80. *Id.* at 214 n.12. The *Royal Drug* Court found that a significant legal distinction existed between reducing the cost of risk and effecting a spreading of the risk. *Id.* The Court explained that “there is an important distinction between risk underwriting and risk reduction. By reducing the total amount it must pay to policyholders, an insurer reduces its liability and therefore its risk. But unless there is some element of spreading risk more widely, there is no underwriting of risk.” *Id.*

81. See *supra* notes 48-50 and accompanying text.

82. *Royal Drug*, 440 U.S. at 215-16. In *National Securities*, the Court reasoned that:

The relationship between insurer and insured . . . [constitutes] . . . the core of the “business of insurance.” Undoubtedly, other activities of insurance companies relate so closely to their status as reliable insurers that they too must be placed in the same class. But whatever the exact scope of the statutory term, it is clear where the focus was - it was on the relationship between the insurance company and the policyholder.

SEC v. National Securities, Inc., 393 U.S. 453, 460 (1969).

Since its decision in *National Securities*, the Court has consistently maintained the distinction evidenced in the above passage. State laws that indirectly regulate insurance by regulating the relationship between the insurer and policyholder remain within the authority given to states by the McCarran-Ferguson Act. By contrast, state laws that indirectly regulate insurance companies by regulating the insurers’ relationships with entities outside the insurance industry do not qualify as regulating the “business of insurance.” See *United States Dep’t of the Treasury v. Fabe*, 113 S. Ct. 2202, 2208, 2212 (1993).

83. *Royal Drug*, 440 U.S. at 216. The Court specifically referred to providers “engaged in the sale and distribution of goods and services other than insurance.” *Id.*

make preferred provider insurance arrangements available to its citizens.⁸⁴ Through a preferred provider statute, the state allows insurers to offer health insurance policies that designate certain “preferred providers.” Moreover, the state allows the insurer to offer its insureds incentives for using preferred providers, and to impose penalties if an insured chooses not to use a preferred provider. A state’s preferred provider statute, taken as a whole, clearly regulates the relationship between the insurer and the insured.⁸⁵

However, an any willing provider provision within this larger statutory scheme works not to regulate the insured-insurer relationship, but instead to regulate the contractual relationship between insurers and providers. With or without the any willing provider law, the insured’s access to certain providers will be limited by the insurance policy. Thus, unlike mandated benefit and mandated provider laws, any willing provider laws do not force an insurer to offer a benefit to the insured that it would not already offer using a fundamental PPO.⁸⁶ The any willing provider law merely forces

84. See *supra* notes 11-20 and accompanying text.

85. Although PPO statutes as a whole regulate the relationship between the insurer and the insured, they do not, as demonstrated above, regulate risk spreading. See *supra* notes 77-81 and accompanying text.

86. The fundamental preferred provider arrangement entails a bifurcation of the total population of providers into two groups. One group consists of the preferred providers who offer discounted services and the other consists of providers either unable or unwilling to participate in contracts for discounted services. The relative ratio of these groups varies from one PPO to the other.

For example, PPO 1 may choose to contract with a very limited number of providers. This PPO will be able to offer extremely low cost health insurance for several reasons. Most notably, it will incur extremely low administrative costs and will be able to contract for significant discounts by offering a few providers the exclusive business of a large field of subscribers. On the other hand, PPO 2 may choose to offer its subscribers a wider choice of providers. In order to cover the increased administrative costs and the cost from lesser discounting on services, PPO 2 will have to charge more for the average policy. Individual consumers must weigh the respective trade-offs between these two PPO alternatives in choosing which policy to purchase. A consumer desiring less expensive coverage and willing to forgo some amount of freedom in choosing a provider will choose PPO 1. Another consumer may choose PPO 2 because he or she wants to have more providers to choose from and is willing to pay more in order to have this increased range of choice.

The typical any willing provider law, such as Virginia’s § 38.2-3407, discussed *supra* note 19, would not change this bifurcation. Moreover, with or without an any willing provider law, PPOs will offer consumers the same “trade-offs.” An any willing provider law allows a PPO to set “terms and conditions” that must be met by providers. Providers who wish to participate in the PPO must meet those “terms and conditions.” A PPO like PPO 1 above will set extremely stringent terms, including significant discounts on fees, mandatory utilization review policies, and uniform billing and communications mechanisms. Few providers will concede this much to participate in the PPO, thus PPO 1 will offer low cost insurance with a limited choice of providers. PPO 2, on the other hand, will accept lower discounts and will impose less control over its participating providers’ practice. Hence, PPO 2

the insurer to make contractual arrangements with additional providers. That is, the number of providers in the preferential arrangement is mandated by the any willing provider law rather than determined by factors of economic efficiency.⁸⁷ Thus, an any willing provider law, when considered alone, regulates only the relationship between insurers and the community of providers, not between insurers and their insureds.

Finally, any willing provider laws do not meet the third element of the *Royal Drug* test—whether the law is confined to entities within the insurance industry. In *Metropolitan Life*, the Court modified this criterion in order to make it directly applicable to the ERISA preemption context.⁸⁸ The Court found that mandated benefit laws regulate insurance because they “impose requirements only on insurers, with the intent of affecting the relationship between the insurer and the policyholder.”⁸⁹

In contrast, any willing provider laws are not confined to entities within the insurance industry because they affect *providers*, not just insurers. Any willing provider laws impose requirements on providers by establishing the “terms” under which they will or will not have a right to participate in a PPO. Unlike mandated benefit laws, any willing provider laws affect the market for providers of health care without affecting the insurer’s relationship with its policyholders.⁹⁰ Thus, neither the intent nor the

will have more providers willing to accept its terms and conditions and, therefore, it will offer its consumers a wider range of choices at a more expensive price.

The any willing provider law only prevents the development of a PPO with features in between the two extremes outlined above—that is, a PPO offering low cost health insurance *along with* a reasonable choice of providers. This is because a PPO with moderately stringent terms and conditions will have to accept the participation of any provider willing to meet those terms and conditions. Such broad acceptance would most likely result in a larger group of providers than would be optimal for the PPO to institute cost effective control mechanisms. Moreover, if too many providers participate no one provider will be assured a large enough increase in patient volume to warrant a significant discount on fees.

87. See *supra* note 11. In order to offer low cost health care insurance along with a reasonable choice of providers, a PPO must be able to choose the economically sound panel of providers. Just as any business must select suppliers of goods and services based, among other things, on factors of supply and demand, PPOs must select providers based on a mixture of economic criteria.

88. *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 743 (1985); see also *supra* note 71.

89. *Metropolitan Life*, 471 U.S. at 743.

90. The practical effect of any willing provider laws, as compared to mandated benefit and mandated provider laws, is evident from the following hypothetical analogy:

If a state legislature were to pass a law requiring all grocery stores to carry vegetables, this law would be functionally equivalent to a mandated benefit law. It would require grocery stores to offer their customers a product which those stores might not choose to offer otherwise. By doing so, this hypothetical law directly regulates the type of relationship a grocery store must have with its customers

practical effect of any willing provider laws is confined to entities within the insurance industry.⁹¹

Any willing provider provisions do not qualify as laws which regulate "the business of insurance." These laws fail to satisfy any of the three *Royal Drug* criteria: they do not effect a spreading of risk; they do not affect an integral part of the relationship between the insured and the insurer; and they are not limited to entities within the insurance industry. Thus, any willing provider laws do not fall within ERISA's saving clause and should be preempted by ERISA.

IV. THE UNCERTAIN FATE OF ANY WILLING PROVIDER LAWS UNDER ERISA

Lower courts now rely on the Supreme Court's three-part test defining the "business of insurance" to resolve issues concerning ERISA's saving clause.⁹² However, whether a particular law is determined to "regulate insurance" for purposes of ERISA's saving clause often depends solely on a court's ability to squeeze the law semantically into or out of one of the three *Royal Drug* criteria. An analysis of the Fourth Circuit's recent use of

(i.e., one in which vegetables are always available).

If another state law required all stores that carry vegetables to sell those vegetables in both fresh and frozen forms, this law would operate more like a mandated provider law. Again, a benefit must be offered to the consumer that the grocery store might otherwise choose not to offer; namely, the benefit of choosing between fresh and frozen vegetables. Again, the relationship between the grocery store and consumer is the focus of the regulation.

Finally, the vegetable equivalent to an "any willing provider law" would require that all grocery stores carrying vegetables purchase those vegetables from any supplier in the state willing to meet a certain price. This law does not guarantee the vegetable consumer any benefit that he does not already have without the law. Vegetables will continue to be available at any store choosing to offer them. Thus, the relationship between the consumer and the grocery store is unaffected. The relationship between the grocery store and its providers, however, has changed significantly. The grocer can no longer, for example, buy from only those providers willing to use electronic order and payment procedures. Moreover, the grocer can no longer form an exclusive contract with only one supplier willing to sell vegetables at greatly discounted prices in return for a steady volume of orders. Most importantly, suppliers in the vegetable market no longer compete based on price and quality; as soon as the grocer's buying price reaches an adequate level, all suppliers have guaranteed sales.

This analogy does oversimplify the issues that arise in a health care setting as opposed to a market for ordinary consumer goods such as vegetables. Yet, the current health care system often obscures the supplier-retailer-buyer relationship that is fundamentally occurring when a doctor agrees to provide medical services to a PPO that sells its packaged product to the buyer of health care. It is also worth noting that analogies between economic goods and health care services are always limited by the degree to which we are willing to equate our mental and physical well being with our purchases of fresh or frozen vegetables.

91. *Union Labor Life Ins. Co. v. Fireno*, 458 U.S. 119, 129 (1982).

92. *See supra* notes 57, 62 and accompanying text.

the three-part test demonstrates this potential for inconsistent results.⁹³ Moreover, the possibility exists that future courts may ignore completely Supreme Court precedent in order to uphold any willing provider laws.⁹⁴

A. *The Fourth Circuit's Misuse of the Royal Drug Test*

The Fourth Circuit applied the *Royal Drug* test in *Stuart Circle Hospital Corp. v. Aetna Health Management*.⁹⁵ Aetna Life Insurance Co. (Aetna)⁹⁶ established a PPO in the Richmond, Virginia, area in 1987 as part of a continuing effort to administer and insure employee benefit plans.⁹⁷ Aetna selected certain hospitals to serve as providers in its PPO. The hospitals selected also participated as providers in Aetna's health maintenance organization that served the Richmond area. By 1992, over 120 employee benefit plans from the Richmond area used Aetna's PPO in various ways. Some of the plans functioned as self-insured entities relying on Aetna only in an administrative capacity and others used Aetna as both the administrator and the insurer of their members' benefits.⁹⁸

93. See *infra* Part IV.A.

94. See *infra* Part IV.B.

95. 800 F. Supp. 328 (E.D. Va. 1992), *vacated*, 995 F.2d 500 (4th Cir.), *cert. denied*, 114 S. Ct. 579 (1993).

96. Although the Aetna Life Insurance Company originally organized the Richmond PPO, a division of the company, Aetna Health Management, formally managed the PPO's operation at the time of the initial lawsuit. *Id.* at 329.

97. *Id.*

98. *Id.* While this distinction seems insignificant on its face, it creates an interesting anomaly in light of the Fourth Circuit's holding that any willing provider laws "regulate insurance" under ERISA § 514(b)(2)(A). See *Stuart Circle*, 995 F.2d at 504 (citing the district court decision, 800 F. Supp. at 336).

The Supreme Court has held that "self-funded" ERISA plans are exempt from state laws even if they "regulate insurance" under ERISA § 514(b)(2)(A). See *FMC Corp. v. Holliday*, 498 U.S. 52, 61 (1990). *FMC Corp.* was based on the Court's interpretation of ERISA § 514(b)(2)(B), the "deemer clause," which provides:

Neither an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

29 U.S.C. § 1144(b)(2)(B) (1988).

In light of ERISA's deemer clause and the holding in *FMC Corp.*, an anomaly results if any willing provider laws are deemed to be laws that "regulate insurance." Employers who self-insure and utilize companies such as Aetna Health Management solely for administrative services will not be subject to any willing provider laws. However, Aetna Health Management's other employer customers who wish to both insure their employees through Aetna's PPO and make use of Aetna's administrative services will find themselves subject to the any willing provider law. Courts consistently justify this anomaly as "merely . . . a distinction created by Congress . . . [that] . . . Congress is aware of and one it has

Aetna did not invite Stuart Circle Hospital Corporation (Stuart Circle) to participate in its PPO. In 1992, Stuart Circle filed suit against Aetna alleging that Aetna had violated Virginia's any willing provider law.⁹⁹ Stuart Circle claimed that Aetna "unreasonably excluded" the hospital from its PPO because Stuart Circle did not serve as part of Aetna's HMO group.¹⁰⁰ Aetna asserted that ERISA preempts Virginia's any willing provider law because the Virginia law "relates to" employee benefit plans.¹⁰¹

The District Court for the Eastern District of Virginia agreed with Aetna and held that ERISA preempted the any willing provider provision within Virginia's PPO statute.¹⁰² On appeal, the Fourth Circuit also agreed with Aetna's initial premise and held that any willing provider laws clearly relate to employee benefit plans.¹⁰³ The court dismissed any further debate as to whether the Virginia statute "relate[s] to" employee benefit plans under the preemption section of ERISA, noting that the Supreme Court's broad interpretation of the "relates to" provision preempts virtually any law that arguably affects employee benefit plans.¹⁰⁴ Thus, the court focused on whether ERISA's saving clause protects any willing provider

chosen not to alter." *Stuart Circle*, 995 F.2d at 504 (quoting *Metropolitan Life*, 471 U.S. at 747).

The practical effect of this anomaly is that Aetna Health Management must divide its PPO customer base into two groups: employees whose employers are large enough to self-insure and employees whose employers need to use Aetna for insurance. Employees of small companies who cannot afford to self-insure their employees' health benefits must absorb the increased costs brought on by allowing any willing provider to participate in their PPOs. Employees of large, self-insuring companies will also see their health insurance rates rise. Because this group can no longer combine with employees from non-self-insuring companies in contracting with providers, the providers are no longer assured the same patient volume. Providers serving this group, therefore, cannot discount prices as much. See *supra* note 8.

99. VA. CODE ANN. § 38.2-3407 (Michie 1994). See *supra* note 19 for the full text of the statute.

100. *Stuart Circle*, 800 F. Supp. at 329.

101. *Id.* at 330.

102. *Id.* at 330, 337. The district court's analysis of the issue was extremely limited. The court first cited three other district court opinions, all of which held that statutes regulating PPOs relate to employee benefit plans for purposes of the preemption clause. *Id.* at 332-33 (citing *General Motors Corp. v. Caldwell*, 647 F. Supp. 585 (N.D. Ga. 1986); *Blue Cross & Blue Shield v. Peacock's Apothecary, Inc.*, 567 F. Supp. 1258, 1276 (N.D. Ala. 1983); and *Adnan Varol, M.D., P.C. v. Blue Cross & Blue Shield*, 708 F. Supp. 826 (E.D. Mich. 1989)). The court then outlined the plaintiff's argument that the any willing provider law satisfied the *Royal Drug* criteria. *Stuart Circle*, 800 F. Supp. at 334. Having found that ERISA's preemption clause preempts Virginia's law, the court simply stated, without comment, that it was not persuaded by the plaintiff's arguments regarding *Royal Drug*. *Id.*

103. *Stuart Circle*, 995 F.2d at 502.

104. *Id.* ("[The Supreme Court] has stated that the 'relates to' language should be given its broad common-sense meaning so as to displace state laws which even indirectly concern themselves with employee benefit plans."); see also *infra* notes 171, 173.

laws against ERISA preemption.¹⁰⁵

In addressing this saving clause issue, the Fourth Circuit initially took a "common-sense" approach.¹⁰⁶ Under its common-sense approach, a law that regulates "the terms of certain insurance contracts" constitutes a law that "regulates insurance."¹⁰⁷ Thus, the Fourth Circuit concluded that Virginia's any willing provider law "regulated insurance" because it affected the insurer-insured relationship and the specific policy that could be issued.¹⁰⁸

The Fourth Circuit's common-sense analysis presents several difficulties. First, the Fourth Circuit ignored the *Royal Drug* precedent. In *Royal Drug*, the Supreme Court explicitly stated that a preferred provider arrangement does not affect the relationship between the insurer and the insured.¹⁰⁹ Instead, the Court held that a preferred provider arrangement affects the relationship between the insured and an entity wholly outside of the insurance industry—a health care provider.¹¹⁰

Second, the Fourth Circuit improperly applied its own common-sense approach. Even if one concedes that a PPO statute as a whole regulates the *type* of insurance contract that an insurer may sell, it does not automatically follow that any willing provider laws present a wholly similar regulatory effect. Any willing provider laws simply regulate the rights of health care providers to participate in preferred provider arrangements.¹¹¹ Regardless of the presence of an any willing provider law, the type of insurance contract available to consumers does not change.¹¹² For example, any willing provider laws do not mandate that an insured's access to providers must be "reasonable."¹¹³ Instead, they mandate that a provider's access

105. *Stuart Circle*, 995 F.2d at 502.

106. *Id.* at 502-03.

107. *Id.* (citing *Metropolitan Life*, 471 U.S. 740-41).

108. *Stuart Circle*, 995 F.2d at 504.

109. *Royal Drug*, 440 U.S. at 216.

110. *Id.*

111. See *supra* notes 88-91 and accompanying text.

112. The Fourth Circuit mischaracterized Virginia's any willing provider law as one that "prohibits an insurer's unreasonable restriction of the insured's choice of physician and hospital." *Stuart Circle*, 995 F.2d at 503 (emphasis added). However, given that PPOs can set the terms and conditions for participation in the PPO, the addition of an any willing provider law does not itself change the choice of providers available to insureds. See *supra* note 86.

113. In contrast, model preferred provider legislation would assure full reimbursement to an insured requiring emergency care who "cannot reasonably reach a preferred provider." PREFERRED PROVIDER ARRANGEMENTS MODEL ACT § 5 (State and Federal Health Insurance Legislative Policy (B) Task Force 1987). Moreover, the model legislation requires that all PPOs "[a]ssure reasonable access to covered services available under the Preferred Provider Arrangement and an adequate number of preferred

to participation in a PPO must be "reasonable," regardless of any effect that the provider's participation may have on the benefits received by the insured.¹¹⁴ Therefore, an any willing provider law does not fit a "common-sense" notion of a law intended to regulate the relationship between the insurer and the insured.¹¹⁵

Following its common-sense analysis, the Fourth Circuit next applied the three-part "business of insurance" test originally established in *Royal Drug*.¹¹⁶ Addressing first the "risk" portion of the test, the Fourth Circuit

providers to render those services." *Id.* § 4(A)(3).

California follows a similar scheme for its "Medicare select" insurers who choose to operate as preferred provider organizations. The state statute allows insurers to offer Medicare supplemental health care coverage through preferred provider arrangements with select providers. Rather than requiring the insurer to contract with "any willing provider," however, California's PPO statute requires an insurer to show:

[e]vidence that all in-network services are available and accessible [to the insured] through [participating] network providers, including a demonstration that: (A) Services can be provided with reasonable promptness with respect to geographic location, hours of operation and after-hours care. The hours of operation and availability of after-hours care shall reflect at minimum, the usual practice in the local area. Geographic availability shall reflect the usual travel times within the community. (B) The number of [participating] providers in the service area is sufficient for prompt service to current and anticipated insureds

CAL. INS. CODE § 10194.4(d)(1)(A)-(B) (West 1993).

Virginia's PPO statute, on the other hand, fails to focus on the relationship between the insurer and the insured. *See supra* note 19.

114. For example, the language of Virginia's any willing provider law mandates that a PPO "shall not discriminate unreasonably against or among . . . health care providers. No hospital, physician or type of provider . . . willing to meet the terms and conditions offered to it or him shall be excluded." VA. CODE ANN. § 38.2-3407(B) (Michie 1994).

Maintaining that the above language regulates the relationship between the insurer and the insured, the Fourth Circuit asserted that the statute "regulates certain insurance contracts, albeit indirectly through the structure of the PPO." *Stuart Circle*, 995 F.2d at 503. However, soon after the *Stuart Circle* decision, the Supreme Court determined that "[t]his argument . . . goes too far." *See United States Dep't of the Treasury v. Fabe*, 113 S. Ct. 2202, 2212 (1993). In *Fabe*, the Court explained that "*Royal Drug* rejected the notion that . . . indirect effects [on the insurer-insured relationship] are sufficient for a state law to avoid pre-emption" *Id.* (citing *Royal Drug*, 440 U.S. at 217); *see supra* note 57; *see also supra* note 86 (explaining that any willing provider laws do not alter the range of choices available to the insured under preferred provider legislation).

115. In *SEC v. National Securities, Inc.*, the Court was asked to decide whether an Arizona state law qualified as "the business of insurance" under the McCarran-Ferguson Act. 393 U.S. 453 (1969). The Arizona law was designed to protect shareholders who owned stock in insurance companies. *Id.* at 458. Holding that the law did not regulate the relationship between the insurer and the insured, the Court stated that "[t]he crucial point is that . . . the state has focused its attention on stockholder protection; it is not attempting to secure the interests of those purchasing insurance policies." *Id.* at 460. In the same way, any willing provider laws focus attention on provider protection and do not secure the interests of a policyholder.

116. *Stuart Circle*, 995 F.2d at 503 (citing *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982), and *Metropolitan Life*, 471 U.S. at 743); *see also supra* notes 48-50 (discussing the development

misclassified the Virginia statute as prohibiting a "restriction of the insured's benefits."¹¹⁷ The court incorrectly equated the statute's prohibition on unreasonable discrimination among providers with a prohibition on restricting an insured's choice of provider.¹¹⁸

This assumption confuses the effect of an any willing provider law with the effect of PPOs generally. The essence of a preferred provider insurance policy is that an insured agrees to shoulder an additional cost when and if the insured chooses to receive care from a nonparticipating provider. However, the presence of an any willing provider law does not alter this penalty feature. A PPO statute does not prohibit insurers from limiting the providers for whose services they will offer full payment. In fact, PPO statutes explicitly allow this limitation on benefits.¹¹⁹ Thus, contrary to the Fourth Circuit's classification, PPO statutes allow insurers to restrict certain benefits to achieve reduced costs and increased quality. An any willing provider law merely mandates the procedure by which a PPO must select its participating providers.

Relying on its own misclassification, however, the Fourth Circuit concluded that the Virginia statute effects a spreading of risk. The court reasoned that the statute spreads the "cost component of the policyholder's risk among all the insureds."¹²⁰ This conclusion demonstrates the court's confusion between spreading risk and minimizing the cost of risk.

The transfer of risk is complete the moment a policyholder enters into a contract for health insurance.¹²¹ If a statute were to require that insurance contracts offer a reasonable choice of participating providers, the statute would effect the spreading of risk at the time of contract.¹²² More

of the *Royal Drug* test).

117. *Stuart Circle*, 995 F.2d at 503; see *supra* notes 77-81 and accompanying text.

118. *Stuart Circle*, 995 F.2d at 503; see *supra* notes 77-81 and accompanying text.

119. For example, Virginia's statute provides that "[o]ne or more insurers may offer or administer a health benefit program under which the insurer or insurers may offer preferred provider policies or contracts that limit the numbers and types of providers of health care services eligible for payment as preferred providers." VA. CODE ANN. § 38.2-3407 (Michie 1994).

120. *Stuart Circle*, 995 F.2d at 503. The court stated:

By its prohibition against unreasonable restriction of providers, the Virginia statute spreads the cost component of the policyholder's risk among all the insureds, instead of requiring the policyholder to shoulder all or part of this cost when seeking care or treatment from an excluded doctor or hospital of his or her choice.

Id.

121. The *Pireno* court stated: "The transfer of risk from insured to insurer is effected by means of the contract between the parties—the insurance policy—and that transfer is complete at the time that the contract is entered." 458 U.S. at 130.

122. See *supra* note 86.

specifically, this hypothetical statute would affect both the amount of risk that each insured transferred to the insurer and, in turn, the amount of risk spread among all of the insureds. Consequently, as long as the insurer continued to fulfill its contractual promise to its insureds, there would be no further spreading of risk.¹²³

Unlike the hypothetical statute described above, any willing provider statutes regulate the arrangements made, or not made, after the policyholder enters into an insurance contract—i.e., after the insurer has already assumed the risk and the cost of coverage. In *Royal Drug*, the Supreme Court referred to these preferred provider arrangements as “merely . . . for the purchase of goods and services . . . [and] . . . not the ‘business of insurance.’”¹²⁴ The *Royal Drug* Court reasoned that the insurer’s decisions to allow only selected providers to participate while denying others this privilege would not effect any further spreading of risk as long as these decisions do not alter the insurer’s promises made under the insurance contract. On the other hand, these decisions may, and most often do, affect the insurer’s cost of providing the promised coverage. *Royal Drug* established that an insurer’s arrangements made simply to “minimize costs and maximize profits” do not constitute part of the business of insurance.¹²⁵

The Fourth Circuit attempted to differentiate *Royal Drug* from *Stuart Circle* on its facts, asserting that the latter entailed a spreading of risk even though the former did not.¹²⁶ The court reasoned that the insurer in *Royal*

123. The Supreme Court explained this distinction in *Royal Drug*. The Court reasoned that “[t]he benefit promised to . . . policyholders is that their premiums will cover the cost of . . . [a preferred provider’s services]. So long as that promise is kept, policyholders are basically unconcerned with arrangements made between [the insurer] and participating [providers].” *Royal Drug*, 440 U.S. at 213-14.

124. *Id.* at 214.

125. *Id.*

126. The court proceeded through a loosely connected set of conclusions in order to determine that Virginia’s statute spreads risk. The court’s initial premise that any willing provider laws themselves prohibit limits on an insured’s benefits was incorrect. *See supra* note 86. The court then correctly reasoned that a limit on one’s benefits can affect the spreading of risk, as shown in the case of mandated benefit laws. *See supra* notes 66-71 and accompanying text. As a third step, however, the court attempted to differentiate the facts of *Royal Drug* on the basis that the agreements in *Royal Drug* did not limit any of the benefits available to the insureds. *See Stuart Circle*, 995 F.2d at 504.

Apparently, the Fourth Circuit thought that a limit on the availability of benefits alone affects the spreading of risk. *Royal Drug*, however, shows that this premise does not hold. *See supra* notes 51-56 and accompanying text. *Royal Drug* held that arrangements for the purchase of goods and services do not affect a spreading of risk, even though they may restrict the availability of benefits. *See Royal Drug*, 440 U.S. at 213-14; *see also supra* note 23.

Drug would have allowed any pharmacy willing to meet the insurer's terms to participate in the arrangement. The court, therefore, suggested that there were no limits on the insureds' benefits in *Royal Drug*.¹²⁷ Conversely, in *Stuart Circle*, the court viewed Aetna's refusal to contract with certain providers as creating a limit on benefits to the insureds.¹²⁸

The Fourth Circuit's rationale ignores both the facts and the holding of *Royal Drug*. The Fourth Circuit presumes that in *Royal Drug* any pharmacy that wanted to participate in Blue Shield's offer could have done so. However, only a limited number of pharmacies could continue to profit under Blue Shield's agreements.¹²⁹ Thus, the terms of the agreements in *Royal Drug* created the same practical effect that the Fourth Circuit found controlling in *Stuart Circle*: insureds could not receive the same benefits by simply using any provider they chose.¹³⁰

The *Royal Drug* Court recognized, as the Fourth Circuit did not, that arrangements which limit the availability of benefits do not necessarily constitute the business of insurance. When the arrangements are with entities outside the insurance industry, they do not involve any underwriting or spreading of risk. Therefore, because any willing provider laws do not regulate relationships that effect risk spreading, they cannot be considered to regulate insurance. The first criterion for the business of insurance definition was not satisfied in *Stuart Circle*.

The Fourth Circuit also incorrectly applied the second *Royal Drug* criterion: whether the law regulates a practice which is an integral part of the relationship between the insured and the insurer. The Fourth Circuit found that Virginia's any willing provider law regulates practices integral

Therefore, even if one accepts that any willing provider laws limit the availability of benefits, it does not follow that these laws effect a spreading of risk. The arrangements that such laws regulate are simply arrangements for the purchase of goods and services outside the insurer-insured relationship. Even if these arrangements limit some of the benefits available to the insured, they do not qualify as the "business of insurance." See *Royal Drug*, 440 U.S. at 214.

127. *Stuart Circle*, 995 F.2d at 504.

128. *Id.*

129. See *supra* notes 51-56 and accompanying text. The typical antitrust suit results when one or a few market players create illegal barriers to competition that others in the market cannot overcome. See, e.g., *Klor's Inc. v. Broadway-Hale Stores, Inc.*, 359 U.S. 207 (1959). If the barriers allegedly created by Blue Shield and its participating pharmacies did not prevent the eighteen independent pharmacies from competing, there would not have been grounds for an antitrust action in the first place. That is, if any pharmacy that wanted to participate could have done so, antitrust litigation would have been unnecessary.

130. *Royal Drug*, 440 U.S. at 213-14 nn.9-11.

to the policy relationship between an insurer and its insured.¹³¹ As with its conclusion concerning the spreading of risk, the Fourth Circuit relied on a misconception of any willing provider laws.

As discussed above, any willing provider laws are fundamentally different from both mandated benefit and mandated provider laws.¹³² The Fourth Circuit, however, analyzed Virginia's any willing provider law as if it were equivalent to other "mandated-provider regulations."¹³³ The court incorrectly characterized any willing provider laws as the mechanism through which the states mandate an insured's choice of providers.¹³⁴ Although mandated provider laws may serve this purpose, any willing provider laws do not.¹³⁵

Relying on this incorrect premise, the Fourth Circuit then looked to the Supreme Court's holding in *Metropolitan Life*. In *Metropolitan Life*, the Court recognized a "matrix" of state laws that regulate the content of health insurance policies.¹³⁶ As examples of this matrix, the Court cited examples of both mandated benefit and mandated provider laws.¹³⁷ The Court implicitly held that these state statutes qualify as laws that regulate the business of insurance. All of the state statutes cited in *Metropolitan Life*, however, are distinguishable from any willing provider laws. Therefore, any willing provider laws fall outside the matrix of laws that the Supreme Court views as regulating the substance of insurance policies.

Finally, the Fourth Circuit gave only cursory attention to the third prong of the *Royal Drug* test. The *Stuart Circle* court simply stated that the any willing provider statute was "expressly 'limited to entities within the insurance industry.'"¹³⁸ This statement ignores the practical effect of any willing provider statutes. Because these laws have a great effect on the

131. *Id.* at 503-04.

132. *See supra* notes 65-76 and accompanying text.

133. *Stuart Circle*, 995 F.2d at 503-04.

134. *See id.* at 503 (stating that Virginia's any willing provider law "prohibits an insurer's unreasonable restriction of the insured's choice of physician and hospital").

135. *See supra* notes 84-86 and accompanying text.

136. *Metropolitan Life*, 471 U.S. at 729.

137. The Court referred specifically to state laws that "require that coverage for services offered by an optometrist be either mandated or at least offered in a health insurance plan." *Id.* at 729 n.9; *see also supra* notes 72-76 and accompanying text (describing mandated provider laws). The Court also included in its analysis laws "requir[ing] alcoholism coverage, . . . birth defect coverage, . . . outpatient kidney dialysis coverage, . . . [and] reconstructive surgery for insured mastectomies." *Metropolitan Life*, 471 U.S. at 729 n.10 (citations omitted); *see also supra* notes 65-71 and accompanying text (describing mandated benefit laws).

138. *Stuart Circle*, 995 F.2d at 504 (quoting *Metropolitan Life*, 471 U.S. at 743).

business of health care and health care providers, they cannot be characterized as only impacting the insurance industry.¹³⁹ Thus, in *Stuart Circle*, the Fourth Circuit incorrectly applied all three elements of the *Royal Drug* test.

B. ERISA's Plain Preemption Language—Discounting the Royal Drug Test

In addition to distorting the *Royal Drug* precedent, courts may be tempted to ignore *Royal Drug* completely in order to save any willing provider laws from ERISA preemption. The Supreme Court established the three-part *Royal Drug* test in 1979 to interpret the McCarran-Ferguson Act.¹⁴⁰ In *Metropolitan Life*, the Supreme Court adopted the three-part *Royal Drug* test in the ERISA context as the touchstone for determining issues under ERISA's saving clause.¹⁴¹ However, a close analysis of ERISA's preemption provision reveals that its language differs significantly from the language of the McCarran-Ferguson Act.¹⁴² In light of this difference, parties may argue that the *Royal Drug* test is inappropriate in the ERISA context.

The McCarran-Ferguson Act gives to the states the primary authority to regulate "the business of insurance."¹⁴³ The Act specifically protects a state's authority to regulate risk spreading activities evidenced by a contractual relationship between an insurer and an insured.¹⁴⁴ The Act does not, however, give states supreme authority to regulate every business decision made by insurance companies, because the Supreme Court distinguishes the "business of insurance" as a unique state-regulated subset of the larger "business of insurance companies."¹⁴⁵

139. See *supra* notes 90-91 and accompanying text.

140. In *Union Labor Life Insurance Co. v. Pireno*, the Supreme Court stated that "*Royal Drug* identified three criteria relevant in determining whether a particular practice is part of the 'business of insurance' exempted from the antitrust laws by § 2(b) [of the McCarran-Ferguson Act]." 458 U.S. 119, 129 (1982).

141. See *supra* notes 47, 57-62 and accompanying text.

142. See *supra* notes 42, 44.

143. See *supra* note 44.

144. See *supra* note 51; see also *supra* note 70 and accompanying text.

145. In *Royal Drug*, the Supreme Court distinguished the "business of insurance" from the "business of insurance companies." *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 217 (1979). The Court pointed out that "[t]he manager of an insurance company is no different from the manager of any enterprise with the responsibility to minimize costs and maximize profits." *Id.* Moreover, the Court refused to accept the contention that any business decision, when made by the manager of an insurance company, becomes the "business of insurance" as that term was used in the

ERISA's saving clause saves from preemption "any law of any State which regulates insurance."¹⁴⁶ Based on this clause alone, one might assume that ERISA saves for state regulation only those laws that the McCarran-Ferguson Act intended to protect.¹⁴⁷ However, in order to protect self-insuring employee benefit plans from state insurance laws, Congress added the "deemer clause" to ERISA's preemption scheme.¹⁴⁸ The deemer clause removes self-insuring employee benefit plans from the reach of any state law "purporting to regulate insurance companies [or] insurance contracts."¹⁴⁹

Viewing ERISA's preemption provision in its entirety, the deemer clause implicitly broadens the scope of the phrase "regulates insurance" as it is used in the saving clause.¹⁵⁰ Without the deemer clause, the reference to laws that "regulate insurance" logically includes only those laws that regulate the "business of insurance" under the McCarran-Ferguson Act. However, the unique wording of the deemer clause implies that Congress intended ERISA's saving clause to preserve state laws that regulate either the business of insurance or the business of insurance companies.¹⁵¹

If Congress had not intended the saving clause to have such a broad scope, the deemer clause would have been unnecessary.¹⁵² That is, unless

McCarran-Ferguson Act. *Id.* The Court found this assertion to be "plainly contrary to the statutory language [of the McCarran-Ferguson Act] which exempts the 'business of insurance' and not the 'business of insurance companies.'" *Id.*

146. See *supra* note 42 and accompanying text.

147. A law that "regulates insurance" would, without additional definition, be the same as a law that regulates the "business of insurance."

148. See *supra* note 42.

149. 29 U.S.C. § 1144(b)(2)(B) (1988).

150. The Supreme Court already recognizes this interpretation of ERISA's plain language. *Metropolitan Life*, 471 U.S. at 740-41. In *Metropolitan Life*, the Court determined that the plain language of the deemer clause clarifies the scope of the saving clause with respect to laws regulating an "insurance contract." *Id.*

Noting that the deemer clause states that an employee benefit plan shall not be deemed to be an insurance company for purposes of any law regulating "insurance contracts," the Court reasoned that "[b]y exempting from the saving clause laws regulating insurance contracts that apply directly to benefit plans, the deemer clause makes explicit Congress' intention to include laws that regulate insurance contracts within the scope of the insurance laws preserved by the saving clause." *Id.* at 741.

151. *Id.*; see also *supra* note 149 and accompanying text.

152. In *Metropolitan Life*, the Court stated that "[u]nless Congress intended to include laws regulating insurance contracts within the scope of the insurance saving clause it would have been unnecessary for the deemer clause explicitly to exempt such laws from the saving clause when they are applied directly to benefit plans." *Metropolitan Life*, 471 U.S. at 741. This reasoning implies that any laws deemed inapplicable to benefit plans under the deemer clause should be saved from preemption under the saving clause.

laws that regulate the "business of insurance companies" are saved from ERISA preemption, there would be no need to protect self-insured employee benefit plans from these laws.¹⁵³ The danger exists that courts will apply this rationale and dismiss the *Royal Drug* three-part test for the "business of insurance" as unduly restrictive of ERISA's saving clause. These courts could then extend the saving clause to preserve a wide range of state laws, including any willing provider laws. This broad interpretation of ERISA's saving clause, and the resulting ambiguity concerning the scope of ERISA preemption, manifests the need for Congress to correct this unnecessarily ambiguous statutory scheme.

V. ANY WILLING PROVIDER LAWS AS "HEALTH LAWS"

Almost a decade after the *Metropolitan Life* decision, any willing provider laws, distinct from the state regulations addressed thus far by the Supreme Court, are providing courts with a new opportunity to reconsider ERISA's preemption language. Courts should seize this opportunity to clarify ERISA preemption doctrine by designating any willing provider laws as "health laws" that are preempted by ERISA.¹⁵⁴ Health laws

153. *Id.*

154. The insurance companies in *Metropolitan Life* proposed that a mandated benefit law should be classified as part of the state's "health law" and not as an insurance law under ERISA § 514(b)(2)(A). *Metropolitan Life*, 471 U.S. at 741. The Supreme Court rejected this proposition with respect to both mandated benefit and mandated provider laws. *Id.* However, other circuits may follow *Stuart Circle* and hold that any willing provider laws cannot be distinguished as "health laws." *Stuart Circle*, 995 F.2d at 504.

Although the health law proposal failed in *Metropolitan Life*, a new definition of "health laws" deserves consideration in the context of the any willing provider law at issue in the *Stuart Circle* case. See *supra* notes 11, 19 and accompanying text; see also LANGBEIN & WOLK, *supra* note 29, at 390 (suggesting that such a distinction could "reconcile the conflicting interests in minimizing state interference in [health laws] while preserving traditional spheres of state regulatory authority over the insurance industry").

The use of the term "health law" in *Metropolitan Life* was considerably different from the one proposed here. The defendants in that case conceded that a mandated benefit law directly affects the substantive terms of insurance contracts. *Metropolitan Life*, 471 U.S. at 741. However, they argued that the law "is in reality a health law that merely operates on insurance contracts to accomplish its end." *Id.* The asserted "end" of a "health law" is not evident in the Court's discussion, and the Court essentially "found linguistic grounds for dismissing the distinction [from insurance laws]." LANGBEIN & WOLK, *supra* note 29, at 390.

The term "health law" has traditionally encompassed "[l]aws, ordinances, or codes prescribing sanitary standards and regulations, designed to promote and preserve the health of the community." BLACK'S LAW DICTIONARY 721 (6th ed. 1990). Although this definition clearly includes mandated benefit laws, it fails to create a mutually exclusive distinction from insurance laws. Thus, a state could use its authority to regulate insurance as a means of "promot[ing] and preserv[ing] the health of the community." *Id.*

possess two main characteristics. First, health laws would fall outside of the Supreme Court's definition of laws regulating the business of insurance.¹⁵⁵ Second, health laws would primarily regulate the distribution of health care goods or services, rather than the business of insurance.¹⁵⁶

Shortly after the *Stuart Circle* decision, the Supreme Court held that, even under a broad interpretation, the "business of insurance" includes only those laws that have a direct effect on the interests of policyholders.¹⁵⁷ Health laws fall outside of this definition because they have only an indirect effect on the interest of policyholders. Rather than regulating the "business of insurance," health laws primarily regulate the market for providers of health care goods and services.

Any willing provider laws fit squarely within the definition of health laws. Any willing provider laws require a PPO to allow a certain number of health care providers to participate in its operations.¹⁵⁸ However, this number is not dictated by the interests of policyholders. Instead, the number is determined by health care providers who would not otherwise be able to participate in the PPO.¹⁵⁹ Thus, because any willing provider laws primarily regulate health care services and distribution, they should be classified as health laws, not laws that regulate the business of insurance.

A mandated benefit law avoids preemption because it is a legitimate exercise of the State's authority over insurance. This is true regardless of whether it also promotes the traditional purposes of "health laws." The type of "health law" proposed herein could have only one primary purpose: to regulate the market for health care goods and services. See *infra* notes 156-57 and accompanying text.

155. See *supra* note 137.

156. "Health care good or services" would be a defined term. Health care services would be defined as all services provided by licensed health care professionals or their agents; health care goods would encompass any medications or other goods provided at the direction of any licensed professional or their agent. See SLEE & SLEE, *supra* note 8, at 191 (defining "health care").

157. *United States Dep't of the Treasury v. Fabe*, 113 S. Ct. 2202, 2212 (1993). The Fourth Circuit's holding in *Stuart Circle* was based primarily on the notion that any willing provider laws regulate the business of insurance "indirectly through the structure of the PPO." See *supra* note 114.

158. See *supra* notes 8, 11, 86-87, 91.

159. Any willing provider laws actually work against the interests of health insurance consumers. Regardless of an any willing provider law, health insurance purchasers must select among various PPOs based on the trade-offs offered between cost and choice as to providers. See *supra* note 86. Any willing provider laws deny consumers the most attractive balance of these trade-offs: a PPO insurance plan with a moderate price and a reasonable range of providers. *Fabe*, 113 S. Ct. at 2212.

On the other hand, any willing provider laws clearly further the interests of health care providers. Competition based on price and quality of care virtually disappears when PPOs are forced to contract with every willing provider in the state. Letter from Michael O. Wise, Acting Director, The Federal Trade Commission, to Hon. Joseph P. Mazurek, Attorney General of Montana (Feb. 4, 1993) (on file at the F.T.C.) [hereinafter Wise Letter]. According to one definition, any willing provider laws "are usually intended to insure that all licensed health care practitioners in a state are allowed equal access to patients who join managed health care plans." WYATT REPORT, *supra* note 11, at 3.

Supreme Court precedent is not conclusive regarding ERISA preemption of health laws. While *Metropolitan Life* may appear limiting, it did not close the door to allowing a preemption distinction for health laws.¹⁶⁰ In *Metropolitan Life*, the Court applied a more narrow reading of the phrase "relates to" in ERISA's preemption provision than it has applied in more recent cases.¹⁶¹ Under this narrow reading, the Court assumed that the type of laws the insurers in *Metropolitan Life* wanted to designate as "health laws" did not "relate to" benefit plans.¹⁶² Using this assumption, the Court reasoned that if ERISA does not preempt health laws, then they need not be saved from preemption by ERISA's saving clause.¹⁶³ Thus, the *Metropolitan Life* Court saw no need to allow a distinction for the health laws proposed in that case.

However, the Supreme Court's recent, expanded interpretation of ERISA's "relates to" language necessitates a distinction for health laws within ERISA's saving clause.¹⁶⁴ At the time of *Metropolitan Life*, the Court clearly did not contemplate the unique preemption issue presented by any willing provider laws.¹⁶⁵ In response to the Court's recent "relates to" interpretation, however, any willing provider laws must be distinguished as "health laws" which "relate to" employee benefit plans, but do not "regulate the business of insurance." Thus, ERISA will preempt any willing provider laws, and ERISA's saving clause will not save them from

160. See *supra* note 154 and accompanying text.

161. See *Metropolitan Life*, 471 U.S. at 741; cf. *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 138-42 (1990) (stating that the preemption clause reaches laws beyond the "specific subjects covered by ERISA"); *Mackey v. Lanier Collection Agency*, 486 U.S. 825, 829 (1988) (stating that the Court has "virtually taken it for granted that state laws which are specifically designed to affect employee benefit plans are preempted").

162. *Metropolitan Life*, 471 U.S. at 741.

163. The following passage evinces the Court's rationale:

This distinction reads the saving clause out of ERISA entirely, because laws that regulate only the insurer, or the way in which it may sell insurance, do not "relate to" benefit plans in the first instance. Because they would not be pre-empted by § 514(a), they do not need to be "saved" by § 514(b)(2)(A). There is no indication that Congress could have intended the saving clause to operate only to guard against too expansive readings of the general preemption clause that might have included laws wholly unrelated to plans.

Id.

164. See *supra* notes 161, 163.

165. In *Stuart Circle*, based on recent Supreme Court rulings regarding the breadth of § 514(a), the Fourth Circuit made only passing reference to the determination that Virginia's any willing provider law clearly "relates to" employee benefit plans. See *Stuart Circle*, 995 F.2d at 502. The district court gave a more complete analysis of this issue, citing three other district court holdings based on similar facts. See *supra* note 102. By contrast, the Fourth Circuit simply stated that the law would be preempted "unless ERISA's insurance saving clause applies." *Stuart Circle*, 995 F.2d at 502.

preemption.

VI. ESTABLISHING A CLEAR PREEMPTION RULE UNDER ERISA

To resolve this problem permanently, Congress must address preemption of any willing provider laws. President Clinton's ill-fated Health Security Act did not contain language resolving this preemption problem. Before the President's proposal was introduced formally in Congress, the Administration intimated that it supported the express preemption of any willing provider laws.¹⁶⁶ However, the Health Security Act failed to provide for clear and complete ERISA preemption of any willing provider laws.¹⁶⁷

Congress should add new definitional language to ERISA's preemption section. Section 514(c) should include the following provision:

(3) The term "regulates insurance" as used in this section shall not include any state law which requires that all or any percentage of providers of health care goods or services be permitted to participate in a preferred provider arrangement except to the extent that such law requires the insurer to provide reasonable access to services covered under the insurance contract.¹⁶⁸

166. Respondent's Brief in Opposition at 20 n.16, *Stuart Circle Hosp. Corp. v. Aetna Health Management*, 995 F.2d 500 (4th Cir.) (No. 93-510) (citing PRELIMINARY DRAFT OF THE PRESIDENT'S HEALTH REFORM PROPOSAL 76 (1993)), *cert. denied*, 114 S. Ct. 579 (1993).

Similarly, the Preferred Provider Health Care Act of 1983, H.R. 2956, 98th Cong., 2d Sess. (1983), would have preempted most state laws that impede the development of PPOs today, but it died in committee in the House of Representatives soon after it was introduced. *See supra* note 78.

167. Some commentators believed that the Health Security Act, at least in its early form, would have preempted state any willing provider laws. *See, e.g.,* Jiranek & Baker, *supra* note 11, at 5; Leo Uzych, *Legislatures Crank Out Managed Care Acts: "Any Willing Provider" Laws Enacted by Many States*, THE LEGAL INTELLIGENCER, Sept. 28, 1994, at 11.

The relevant section of the proposed bill was Title VIII, Subtitle E, labeled "Amendments to the Employee Retirement Income Security Act of 1974." H.R. 3600, 103d Cong., 1st Sess. (1993). The bill proposed to add a new subsection to ERISA's present § 4. The new subsection, labeled "Applicability of Preemption Rules," provides that "[ERISA] Section 514 shall apply in the case of any group health plan. . . ." *Id.* § 8402. The bill defined a "group health plan" as "an employee welfare benefit plan which provides medical care . . . to participants or beneficiaries directly or through insurance, reimbursement, or otherwise." *Id.* § 8401.

Merely making ERISA § 514 "applicable" to group health plans would not address the obvious ambiguities in ERISA's preemption provision. The term "regulate insurance" in § 514 needs to be clarified so that states cannot continue to encroach on "health laws" as they are defined in this Note. *See supra* notes 164-166 and accompanying text.

168. Without question, a definitional term of this kind will not eliminate all of the problems arising out of ERISA's preemption scheme. This definition, however, addresses the specific problem of any willing provider laws in light of the growing importance of PPOs as a managed health care alternative.

The proposed definition is a hybrid of two separate sources. The Health Maintenance Organization Act of 1973 exempts qualified HMOs from any state law that "requires that all physicians or a percentage of physicians in the locale participate or be permitted to participate in the provision of

This provision allows states to continue to regulate the substantive terms of insurance contracts. Yet it also allows the federal government to retain its regulatory powers over the market for health care goods and services. For example, mandated provider and mandated benefit laws would continue to qualify under the saving clause as laws which "regulate insurance."¹⁶⁹ Similarly, laws requiring PPOs to provide policyholders with reasonable access to services covered under the insurance contract would not be preempted.¹⁷⁰ Because these laws directly affect the interests of policyholders they would continue to be part of the "regulation of insurance" under ERISA's saving clause, section 514(b)(2)(A).¹⁷¹

Empirical data support passage of a provision such as the one proposed above. PPOs consistently demonstrate an ability to reduce the costs of delivering health care while maintaining high levels of satisfaction among patients and physicians who participate in the arrangement.¹⁷² Any willing provider laws increase administrative costs and reduce provider discounts. These effects translate directly into increased health care insurance premiums and decreased competition in the health care market.¹⁷³

services for the entity." 42 U.S.C. § 300e-10(a)(1)(C) (Supp. III 1991). This provision, however, leaves some ambiguity as to whether a state law may regulate the risk spreading activities of insurers that specifically affect the relationship between the insurer and the insured. For example, a state law requiring PPOs to guarantee their insureds reasonable access to covered services may constitute a law that "requires that . . . a percentage of physicians in the locale participate." *Id.*

In an effort to avoid this problem, the proposed definition incorporates language used in model preferred provider legislation that focuses directly on the relationship between the insurer and the insured. The model language requires any PPO to "assure reasonable access to" services covered within the insurance agreement. See *Preferred Provider Arrangements Model Act*, *supra* note 113, § 4(a)(3).

169. A state could mandate that certain benefits and services provided by certain types of providers must be covered under any health insurance contract. In addition, a state may require that a PPO assure its insureds "reasonable access to the services covered under the insurance contract." So long as a state law does not require provider participation beyond this minimum level, the state law would be saved from ERISA's preemption.

170. State common law determinations would still have to establish the standard by which a PPO would prove that it has provided "reasonable access" to its insureds. Thus, some small degree of national disuniformity would inevitably result.

171. See *supra* note 42.

172. HOSEK ET AL., *supra* note 8, at 12. This study concluded that "[t]he levels of satisfaction among PPO participants are at least as high and sometimes higher than the levels for nonPPO participants. Similarly, very few PPO physicians would change their original decision to join the PPO." *Id.*

173. A recent study by the Wyatt Company found that costs would increase dramatically if any willing provider laws increased provider participation in PPOs. The study assumed that physician participation might increase from the current level of 25% to 60%. Moreover, the current level of hospital participation in PPOs is 44%; the study assumed this might rise to 80%.

Given these assumptions, the Wyatt Company found that any willing provider laws would result in

VII. CONCLUSION

In 1979, the Supreme Court established the three-part *Royal Drug* test for determining whether a law regulates the "business of insurance."¹⁷⁴ In 1985, the Court first applied this test to determine whether state laws are saved from ERISA preemption.¹⁷⁵ Today, with respect to any willing provider laws, the *Royal Drug* test has the potential to create more problems than it solves.

Distinguishable from mandated benefit and mandated provider laws, any willing provider laws do not fit comfortably into any of the three essential criteria defining the "business of insurance."¹⁷⁶ Yet, as the Fourth Circuit's decision in *Stuart Circle* demonstrates, courts may manipulate the *Royal Drug* test to save any willing provider laws from ERISA preemp-

an 8.8% rise in claims costs and a 34% rise in administrative costs. The current average discount on medical services would consequently drop from 19.5% to 9.4%. Furthermore, these effects would translate into a 12.6% increase in the average cost of insurance premiums under the PPO model. Wojcik, *supra* note 10, at 18 (citing WYATT REPORT, *supra* note 11).

The FTC recognized these detrimental effects and issued opinion letters urging states to discontinue laws that prohibit insurers from maintaining cost effective preferred provider arrangements. See Wise Letter, *supra* note 159; see also Letter from Michael O. Wise, Acting Director, The Federal Trade Commission, to Hon. Roger A. Madigan, Pennsylvania State Senator (April 19, 1993) (on file at the F.T.C.) (addressing proposed state law requiring that any pharmacy be permitted to participate in preferred provider arrangements); Letter from Michael O. Wise, Acting Director, The Federal Trade Commission, to Hon. Patrick Johnston, California State Senator (June 26, 1992) (on file at the F.T.C.) (addressing proposed law prohibiting exclusive contracts with nonresident pharmacies); Letter from Michael O. Wise, Acting Director, The Federal Trade Commission, to Mr. Paul J. Alfano, New Hampshire Senate Legal Counsel (March 17, 1992) (on file at the F.T.C.) (addressing proposed law requiring health maintenance organizations to contract with any pharmacy meeting a set bid).

During the past two years, the Federal Trade Commission has issued advisory opinion letters to four different states addressing the effects of any willing provider laws. In its most recent letter, the Federal Trade Commission presented the Attorney General of Montana with the following opinion regarding Montana Code § 33-22-1704:

This law limits the ability of preferred provider organizations ("PPOs") to arrange for services through contracts with health care providers, by requiring a PPO to enter a contract with any provider willing to meet the terms the PPO sets. By preventing PPOs from limiting the panel of providers, the law discourages contracts with providers in which lower prices are offered in exchange for the assurance of higher volume. Although the law may be intended to assure consumers greater freedom to choose where they obtain services, it appears likely to have the unintended effect of denying consumers the advantages of cost reducing arrangements and limiting their choices in the provision of health care services.

Wise Letter, *supra* note 159.

174. See *supra* notes 48-50 and accompanying text.

175. See *supra* notes 59-62 and accompanying text.

176. See *supra* Part III.

tion.¹⁷⁷ In addition, courts may plausibly interpret ERISA's saving clause, in light of its deemer clause, to reach any willing provider laws.¹⁷⁸

This potential confusion must be resolved. First, courts should recognize a distinct classification of "health laws," including any willing provider laws, clearly preempted by ERISA.¹⁷⁹ Second, Congress must adopt a definitional provision such as that proposed above to clarify ERISA's preemption language, and to distinguish any willing provider laws from laws that "regulate insurance."¹⁸⁰ The scope of ERISA preemption must be firmly established in order to clear the way for a coherent national health care policy.

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177. *See supra* Part IV.A.

178. *See supra* Part IV.B.

179. *See supra* Part V.

180. *See supra* Part VI.

